Date: ______________________ Referring Physician Name and Address: ____

Main Reason for Visit:

- ☐ Adnexal mass
- ☐ Abnormal Uterine Bleeding
- ☐ Endometriosis
- ☐ Fibroids
- ☐ Pelvic Pain
- ☐ Polyp
- ☐ Postmenopausal bleeding
- ☐ Other ______________________________

Gynecologic History:

Age at first period: ______ Date of last menstrual period: ____________________

If not menstruating, stopped at age: _____ because of:

- ☐ Menopause
- ☐ Uterus removed for ___________________(reason)

Are your periods:

- ☐ Regular
- ☐ Irregular

How often do your periods come? ______________________ How many days does your period last? __________

Do you bleed or spot outside of your period?

- ☐ Yes
- ☐ No

Do you have pain with your period?

- ☐ Yes
- ☐ No

Scale 1 to 10 ________

Do you have pain outside your period?

- ☐ Yes
- ☐ No

Where do you feel the pain: _______________________

Do you miss work or activities because of your period?

- ☐ Yes
- ☐ No

What do you take for pain for your periods? ____________________________________

Date of last Pap smear: ____________ Result of Pap smear: ______________________

Have you ever had an abnormal Pap smear?

- ☐ Yes
- ☐ No

If Yes, When? ________________________

How was it treated? (circle below)

Colposcopy	Cone Biopsy	Cryosurgery (freezing)	Laser Surgery
Loop Excision (LEEP)	Hysterectomy	Repeat Pap Smear	

Do you have pain with urination?

- ☐ Yes
- ☐ No

Do you have blood with urination?

- ☐ Yes
- ☐ No

Do you have bowel movements daily?

- ☐ Yes
- ☐ No

If No, How often? _________________

PATIENT INTAKE

Do you have pain with bowel movements?
- ☐ Yes
- ☐ No

Do you have blood with bowel movements?
- ☐ Yes
- ☐ No

Are you currently sexually active?
- ☐ Yes
- ☐ No

With
- ☐ Men
- ☐ Women
- ☐ Both

If No, have you ever been sexually active?
- ☐ Yes
- ☐ No

Do you have pain with sexual intercourse?
- ☐ Yes
- ☐ No

Do you bleed with sexual intercourse?
- ☐ Yes
- ☐ No

Do you use contraception?
- ☐ Birth control pills
- ☐ Condoms
- ☐ IUD
- ☐ Tubal ligation
- ☐ Vasectomy
- ☐ Shots
- ☐ Patch
- ☐ Ring
- ☐ No method
- ☐ Other____

Any history of pelvic infections?
- ☐ Yes
- ☐ No

If Yes: Chlamydia Gonorrhea Syphilis Trichomonas HIV/AIDS

Reproductive History:

How many pregnancies have you had? _____ Vaginal deliveries _____ C-sections _____ Tubal pregnancies _____
Miscarriages _____ Abortions _____ Stillbirths _____

Past Medical/ Surgical History:

Please check any problem you have been diagnosed with or received treatment for:

- ☐ Anemia
- ☐ Heart attack
- ☐ Heart murmur
- ☐ Congestive heart failure (CHF)
- ☐ Angina
- ☐ High blood pressure
- ☐ Atrial fibrillation
- ☐ Mitral valve prolapse
- ☐ Asthma
- ☐ Allergies/hay fever
- ☐ Bronchitis
- ☐ Emphysema
- ☐ COPD
- ☐ Diabetes
- ☐ Thyroid
- ☐ Bone disease/osteoporosis
- ☐ Previous cancer _________________
- ☐ Jaundice/cirrhosis
- ☐ Gallstones
- ☐ Stomach ulcer
- ☐ Hernia
- ☐ Irritable bowel syndrome
- ☐ Colitis _________________________
- ☐ Chronic diarrhea
- ☐ Hemorrhoids
- ☐ Arthritis
- ☐ Fibromyalgia
- ☐ Sjogren's syndrome
- ☐ Back/neck/spine problems
- ☐ Migraines
- ☐ Seizures
- ☐ Kidney failure
- ☐ Kidney stone
- ☐ Blood clot in leg or lung
- ☐ Phlebitis
- ☐ Bleeding disorder (van Willebrand)
- ☐ Varicose veins
- ☐ Glaucoma
- ☐ Skin disease _____________________
- ☐ Depression
- ☐ Anxiety
- ☐ Bipolar
- ☐ Schizophrenia
- ☐ Dementia/Alzheimer's
- ☐ Other ____________________________

Screening and Diagnostic Tests:

Have you ever had a bone density test?
- ☐ Yes
- ☐ No

Have you ever had a colonoscopy?
- ☐ Yes
- ☐ No

Date of last colonoscopy: ______________________________

Have you ever had a mammogram?
- ☐ Yes
- ☐ No

Date of last mammogram: ___________________________

Have you ever had a cystoscopy?
- ☐ Yes
- ☐ No

In the last year, have you had any
- ☐ X-Rays
- ☐ CT scans
- ☐ MRI scans
- ☐ Ultrasounds (sonograms)?

If yes, list body part imaged and the facility where performed:

____

____

Surgery: Please list all previous surgeries.

Year	Gyn/Breast Surgery (any surgery on ovary, uterus, cervix, D&C, LEEP, C-Section)	Year	Orthopedic Surgery (knee, hip replacement, back or bone surgery
Year	Other Abdominal Surgery (colon, hernia, bowel, stomach, gallbladder)	Year	Other Abdominal Surgery (colon, hernia, bowel, stomach, gallbladder)
Year	Other Surgery (eye, lung, kidney, etc.)		

Have you ever been advised to have any surgical procedure which has not been done? ☐ No ☐ Yes: ___________________

____

Have you ever been hospitalized for illnesses? ☐ No ☐ Yes, reason/year: ______________________________

Have you ever had a blood transfusion? ☐ No ☐ Yes, reason/year: ______________________________

Doctors: Please list the doctors who care for you.

Specialty:	Name	Phone	Send notes?*
Gyn			☐ Yes ☐ No
Primary Care			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

*Mark yes is you would like to send information to you other doctors after each office visit. Preferred Pharmacy:

Preferred Pharmacy:

☐ CVS ☐ Kroger ☐ Other ______________________________

☐ Rite Aid ☐ Publix

☐ Walmart ☐ Walgreens

Address:____ Phone: ____________________________

Are you allergic to any medications?

☐ Yes

☐ No

If Yes, Please list all allergies to medications, food and materials (i.e., latex, adhesives, etc.) and the type of reaction (for example, hives, rash, swelling of throat, vomiting, etc.)

Medication and Reaction	**Medication and Reaction**

Do you have any environmental or food allergies?

☐ Yes

☐ No

Are you allergic to latex?

☐ Yes

☐ No

Are you allergic to betadine?

☐ Yes

☐ No

Please list all medications you are taking with dosages and number of times a day (please list all vitamins and herbs)

Name of Medication	**Dosage**	**When do you take it?**	**Who prescribed it?**

Family History: Please list any family member diagnosed with these diseases and whether they are alive (A) or deceased (D) from the disease.

	Close Family Members (child, sibling or parent)	Extended Family Members (aunts, uncles, grandparents, cousins)
Ovarian Cancer		
Breast Cancer		
Endometrial Cancer		
Cervical Cancer		
Prostate Cancer		
Colon Cancer		
Other Cancer		
Diabetes		
History of bleeding tendencies		
Stroke		
High blood pressure		
History of blood clots (i.e. lungs, legs)		

Social History:

Do you smoke? ☐ Yes ☐ No Packs per day: _________ Number of years: _________ When did you quit? _______________

Do you use any other form of tobacco? ☐ Yes ☐ No If yes, type: ____

Do you use alcohol? ☐ Yes ☐ No Amount per week? _________ Type: ____

Have you ever used drugs? ☐ Yes ☐ No ☐ Past ☐ Present What type? ____

Do you exercise routinely? ☐ Yes ☐ No How often per week? ___________ What type? ______________________________

Do you have concerns about you personal safety, the personal safety of anyone in your home, or the security of your property? ☐ Yes ☐ No

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Domestic partner

Ages of children: ____

Education: ☐ High school ☐ College ☐ Graduate school

Occupation: _______________________________________ ☐ Retired ☐ Disabled due to _________________________________