Cascadia women's clinic

GYNECOLOGIC INTAKE HISTORY

Name: _____ Date: ____ / ____ / ____

Address: _____ Birthdate: ____ / ____ / ____

City: _____ Home Tel: (____) _____

State/Zip: _____ Work Tel: (____) _____

Employer: _____ Insurance: _____

Name of Spouse/Partner: _____ Referred by: _____

Please check (✓) appropriate box if any of the following apply to you now or have applied in the past:

	CURRENTLY	PAST	NOTES
1. CONSTITUTIONAL			
Weight Loss	❑	❑	
Weight Gain	❑	❑	
Fever	❑	❑	
Fatigue	❑	❑	
2. EYES			
Double Vision	❑	❑	
Spots Before Eyes	❑	❑	
Vision Changes	❑	❑	
3. ENT/MOUTH			
Ear Aches	❑	❑	
Ringing in Ears	❑	❑	
Sinus Problems	❑	❑	
Sore Throat	❑	❑	
Mouth Sores	❑	❑	
Dental Problems	❑	❑	
4. CARDIOVASCULAR			
Painful Breathing	❑	❑	
Chest Pain	❑	❑	
Difficult Breathing on Exertion	❑	❑	
Swelling of Legs	❑	❑	
Palpitations of Heart	❑	❑	
5 RESPIRATORY			
Wheezing	❑	❑	
Spitting up Blood	❑	❑	
Shortness of Breath	❑	❑	
Chronic Cough	❑	❑	
6. GASTROINTESTINAL			
Frequent Diarrhea	❑	❑	
Blood Stool	❑	❑	
Nausea/Vomiting	❑	❑	
Constipation	❑	❑	
7. GENITOURINARY			
Blood in Urine	❑	❑	
Pain with Urination	❑	❑	
Urgency	❑	❑	
Frequency of Urination	❑	❑	
Incomplete Emptying	❑	❑	
Stress Incontinence	❑	❑	
Abnormal Periods	❑	❑	
Painful Intercourse	❑	❑	
8. MUSCULOSKELETAL			
Muscle Weakness	❑	❑	
9. SKIN/BREAST			
Pain in Breast	❑	❑	
Discharge	❑	❑	
Masses	❑	❑	
Rash	❑	❑	
Ulcers	❑	❑	

Please check (✓) appropriate box if any of the following apply to you now or have applied in the past:

	CURRENTLY	PAST	NOTES
10. NEUROLOGICAL			
Dizziness	❑	❑	
Seizures	❑	❑	
Numbness	❑	❑	
Trouble Walking	❑	❑	
11. PSYCHIATRIC			
Depression	❑	❑	
Frequent Crying	❑	❑	
12. ENDOCRINE			
Dry Skin	❑	❑	
Abnormal Thirst	❑	❑	
Hot Flashes	❑	❑	
13. HEMATOLOGIC/LYMPHATIC			
Frequent Bruises	❑	❑	
Cuts that Do Not Stop Bleeding	❑	❑	
Enlarged Lymph Nodes	❑	❑	
14. ALLERGIC/IMMUNOLOGIC			
Allergies	❑	❑	
Drug Allergy	❑	❑	

PERSONAL PAST HISTORY

MAJOR ILLNESSES	YES	NO	MAJOR ILLNESSES	YES	NO
Asthma	❑	❑	Cancer	❑	❑
Pneumonia	❑	❑	Ulcers	❑	❑
Chronic Lung Disease	❑	❑	Depression/Anxiety	❑	❑
Kidney Infections/Stones	❑	❑	Anemia/Blood Transfusions	❑	❑
Tuberculosis	❑	❑	Seizures/Convulsions/Epilepsy	❑	❑
Venereal Disease	❑	❑	Bowel Trouble	❑	❑
Heart Trouble/Murmur	❑	❑	Glaucoma	❑	❑
Diabetes	❑	❑	Arthritis/Joint Pain	❑	❑
High Blood Pressure	❑	❑	Fracture	❑	❑
Stroke	❑	❑	Hepatitis/Yellow Jaundice	❑	❑
Rheumatic Fever	❑	❑	Thyroid Disease	❑	❑

OPERATIONS / HOSPITALIZATIONS (Describe reason for operation / hospitalization)

	DATE		DATE

INJURIES / ILLNESS (Describe type of injury / illness)

	DATE		DATE

LAST IMMUNIZATION OR TEST

	DATE		DATE
Tetanus		Pneumonia	
Flu Shot		TB Skin Test	

OB / GYN HISTORY

	NUMBER		NUMBER
Births		Abortions	
Miscarriages		Living children	

CURRENT MEDICATIONS (List drug name[s] and dosage[s])

	DOSAGE(S)		DOSAGE(S)

FAMILY HISTORY

Please check (✓) yes if a family member has or had one of these illnesses:

ILLNESS	YES	NO	FAMILY MEMBER	ILLNESS	YES	NO	FAMILY MEMBER
Diabetes	❑	❑	_____	Drinking Problem	❑	❑	_____
Stroke	❑	❑	_____	Breast Cancer	❑	❑	_____
Heart Disease	❑	❑	_____	Colon Cancer	❑	❑	_____
High Blood Pressure	❑	❑	_____	Ovarian Cancer	❑	❑	_____

SOCIAL HISTORY

Personal Habits:

	YES	NO
Smoking	❑	❑
Alcohol	❑	❑
Drug Use	❑	❑
Seat Belt Use	❑	❑
Regular Exercise	❑	❑

Packs per day: _____ Years: _____

Drinks per day: _____ Drinks per week: _____

Personal Profile:

Marital Status: Married ❑ Single ❑ Widowed ❑ Divorced ❑

Number of Living Children: _____

Number of people in household: _____

School Completed: High School ❑ College ❑ Graduate Degree ❑ Other ❑ _____

Current or most recent job: _____

Personal Safety:

	YES	NO
Has anyone close to you ever threatened to hurt you?	❑	❑
Has anyone ever hit, kicked, choked, or hurt you physically?	❑	❑
Has anyone, including your partner, ever forced you to have sex?	❑	❑
Are you ever been afraid of your partner?	❑	❑

MEDICARE "HIGH RISK" CRITERIA

Please check (✓) if you have ever been treated for any of the following infections:

Vaginosis	❑	Genital Warts	❑	Chlamydia	❑
Trighomonas	❑	Gonorrhea	❑	Syphilis	❑

	YES	NO	
Have you had a Pap smear in the last 7 years?	❑	❑	
Have you ever had an abnormal Pap smear test?	❑	❑	If so, when? _____
Did you begin sexual activity before you were 16 years old?	❑	❑	
Have you had more than 5 sexual partners in your lifetime?	❑	❑	
Have you ever tested positive for the HIV virus?	❑	❑	
Did your mother take the drug DES when she was pregnant with you?	❑	❑	

Completed by: Patient ❑ Office Nurse ❑ Physician ❑

Signature of patient: _____

Date reviewed by physician with patient: _____

Physician Signature: _____

Annual Review of History:

Date reviewed: _____ Physician Signature: _____

Date reviewed: _____ Physician Signature: _____

Date reviewed: _____ Physician Signature: _____