MEDICAL HISTORY INTAKE FORM

DATE: _____/_____/_____ AGE: _____
NAME: _____ BIRTH DATE: _____ /_____/_____
PRIMARY CARE MD: _____ HEIGHT: _____

ALLERGIES

MEDICATIONS

Drug Names	Dosage	Drug Names	Dosage

GYN HISTORY

Menstrual History
What is the first day of your last menstrual period? _____ How long does it last? _____
How many days apart are your menstrual cycles starting from the first day of one cycle to the first day of your next cycle?_____
What age did you start having menses? _____

When was your last PAP smear? _____
Have you ever had an abnormal Pap smear? £ No £ Yes When? _____
What abnormality? _____

Have you ever been treated for: £ Chlamydia £ Gonorrhea £ Genital Warts
£ Herpes £ Trichomonas £ Syphilis

Have you ever tested positive for HIV? £ No £ Yes
Did you mother take the drug DES when she was pregnant with you? £ No £ Yes

Are you currently sexually active? £ No £ Yes £ Never
Did you begin sexual activity before 16yo? £ No £ Yes If yes, Age started: _____
Have you had > 5 sexual partners in your lifetime? £ No £ Yes If yes, how many? _____
Sexual Orientation _____

Are you currently using birth control? £ No £ Yes £ Trying to get pregnant
Current birth control: _____ Are you satisfied with it: £ No £ Yes

Past Birth control methods:

£Condoms	£Birth control pills	£ Withdrawal	£Tubal Ligation
£Diaphragm	£Patch	£Rhythm	£Vasectomy
£Vaginal Film	£Vaginal Ring	£ IUD	£ Essure

Last Mammogram?_____ Last Skin Check?_____
Last Colonoscopy?_____ Last Dexa Bone Density Scan?_____

PREGNANCY HISTORY

	Number		Number		Number
Total times pregnant		Full term deliveries		Cesarean sections	
Miscarriages		Deliveries before 37 weeks		Forceps or vacuums	
Abortions		Living children			
Describe any special pregnancy problems:					

PERSONAL MEDICAL HISTORY

MAJOR ILLNESSES	YES		YES		YES
Diabetes		Heart Disease		Anxiety	
High Blood Pressure		High cholesterol		Depression	
GI Reflux disease		Hepatitis		Seizures	
Other GI disease		Liver problem		Asthma	
Fibroids		Kidney infections/stones		Lung disease	
Endometriosis		Arthritis		Tuberculosis	
Osteopenia		Joint Pain		Thyroid disease	
Osteoporosis		Fracture		Clotting disorder	
Cancer (Type)					
Add others/Explain:					

SURGICAL HISTORY

SURGERY	YEAR	SURGERY	YEAR

FAMILY HISTORY

MAJOR ILLNESSES	YES		YES		YES
Diabetes		Heart Disease		Anxiety	
High Blood Pressure		High cholesterol		Depression	
GI Reflux Disease		Hepatitis		Seizures	
Other GI disease		Liver problem		Asthma	
Fibroids		Kidney infections/stones		Lung disease	
Endometriosis		Arthritis		Tuberculosis	
Osteopenia		Joint pain		Thyroid disease	
Osteoporosis		Fracture		Clotting disorder	
Cancer (Type)					
Add others/Explain:					

SOCIAL HISTORY

Personal Profile
Occupation: _____ Preferred Language: _____ Birth Place: _____ Ethnicity: _____
£Married £ Single £ Divorced £ Widowed £ Significantly Involved £ Domestic Partner
Exercise: £Yes £ No How often _____ Type: _____ Special Diet: £Yes £No Type:
Education Level: £High school £ College £ Graduate degree £ Other
Habits
Smoking: £Yes £ No Packs/day _____ Years _____ Quit when: _____ Alcohol: £Yes £ No Drinks/day _____ Drinks/week: _____ Quit when:_____ Drug Use: £Yes £ No Type _____ Years _____ Quit when:_____ Caffeine: £Yes £ No Cups per day _____ Cups per week: _____ Do you use seatbelts? £Yes £ No Do you use sunscreen? £Yes £ No
Personal Safety
£Yes £ No Has anyone close to you ever threatened to hurt you? £Yes £ No Has anyone ever hit, kicked, choked or hurt you physically?

Has anyone, including you partner, every forced you to have sex? £ Yes £ No Are you ever afraid of your partner? £ Yes £ No

REVIEW OF SYSTEMS (CURRENT SYMPTOMS)

1. CONSTITUTIONAL	7. GENITOURINARY
Fever £	Abnormal Bleeding £
Chills £	Vaginal discharge/ odor £
Fatigue £	Vaginal itching/ burning £
Weight Loss £	Pelvic pain £
Weight gain £	Menstrual cramps £
2. EYES	Painful intercourse £
Changes in vision £	Genital lump £
Double vision £	Fertility concerns £
3. ENT/ MOUTH	Menopausal concerns £
Ear aches £	8. MUSCULOSKELETAL
Ringing in the ears £	Muscle weakness £
Sinus problems £	Joint stiffness £
Sore throat £	Joint pain £
Mouth sores £	Joint swelling £
Dry Mouth £	9. SKIN/ BREAST
4. CARDIOVASCULAR	Breast pain £
Chest pain £	Nipple discharge £
Difficulty breathing on exertion £	Breast lumps £
Swelling of legs £	Rash £
Palpitations £	Ulcers £
Heart Murmurs £	11. PSYCHIATRIC
5. RESPIRATORY	Depression £
Wheezing £	Mood swings £
Spitting up blood £	Anxiety £
Shortness of breath £	Suicidal thoughts £
Cough £	Homicidal thoughts £
6. GASTROINTESTINAL	12. ENDOCRINE
Diarrhea £	Abnormal thirst £
Constipation £	Hot flashes £
Nausea/vomiting £	Tremors £
Bloody stool £	Cold/ heat intolerance £
Abdominal pain £	13. HEMATOLOGIC
Indigestion £	Frequent bruising £
Bloating £	Cuts do not stop bleeding £
Liver problem/Hepatitis £	Enlarged lymph nodes £
7. GENITOURINARY	
Blood in urine £	
Pain with urination £	
Urgency £	
Urinary Frequency £	
Urinary Incontinence £	