# HISTORY INTAKE

**Today's Date:** _____

**Last Name:** _____ **First Name:** _____ **Date of Birth**: _____

Important: In order to provide the highest quality health care possible, it is important that we have the following information. Please answer all the questions as accurately as possible. If you do not understand the question, please ask for assistance. Thank you.

**PHARMACY** _____ **PHARMACY PHONE** _____

Address _____ City _____ State _____ Zip _____

**PRIMARY CARE PHYSICIAN** _____ **PCP PHONE:** _____

Address _____ City _____ State _____ Zip _____

***TELLS US ABOUT OTHER PHYSICIANS WHO YOU MAY SEE:***

**PHYSICIAN** _____ **SPECIALTY:** _____ _____

Phone: _____ Address _____

**PHYSICIAN** _____ **SPECIALTY:** _____ _____

Phone: _____ Address _____

**LIST ANY ALLERGIES:** _____

_____

**LIST ALL MEDICATIONS: PRESCRIBED, OVER THE COUNTER AND HERBAL**

May we have your permission to contact your insurance to obtain a list of the medications you have had filled during the last 13 months? YES NO

| MEDICATION/DOSE/FREQUENCY | MEDICATION/DOSE/FREQUENCY |
|---|---|
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| | |
| | |
| | |

**Last Name:** _____ **First Name:** _____ **Date of Birth**: _____

**GYN HISTORY**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Age your period began: | | | | | | | |
| Date of Last Pap Smear | | | | | | | |
| Have you ever had an abnormal pap smear? | Yes | No | | | | | |
| Are you sexually active? | Yes | No | If Yes, | Men | Women | Both | |
| Current Birth Control Method | | | | | | | |
| Have you ever been diagnosed with any sexually transmitted infection or disease? | | | | | | | |
| Have you had an HPV vaccine? | | | | | | | |
| If Post Menopausal, Age at Menopause | | | | | | | |
| Are you currently taking any Hormone Replacement Therapy medications? | Yes | No | Have you ever taken any Hormone Replacement Therapy medications? | | | Yes | No |
| Have you had any post menopausal bleeding? | Yes | No | | | | | |
| Date of Last Mammogram: | | | | | | | |
| Date of Last Colonoscopy: | | | | | | | |
| Date of most recent bone density? | | | | | | | |

**OBSTETRICAL HISTORY**

Have you ever been pregnant? (Including termination of pregnancy) YES NO

How many times have you been pregnant? _____

□ number of full-term delivery(s) _____ □ number of premature delivery(s) _____

□ number of terminations/abortions _____ □ number of miscarriages _____

□ number of tubal pregnancies _____ □ number of twins/triplets _____

How many children living? _____

**PAST PREGNANCIES**

**Last Name:** _____ **First Name:** _____ **Date of Birth**: _____

| | Delivery Date | # of Fetus | Weight | Sex | Delivery Type | Full-term or Pre-mature | Complications during pregnancy or delivery |
|---|---|---|---|---|---|---|---|
| 1 | | | | | | | |
| 2 | | | | | | | |
| 3 | | | | | | | |
| 4 | | | | | | | |
| 5 | | | | | | | |
| 6 | | | | | | | |

**PAST MEDICAL HISTORY: Circle all that apply.**

| | | | |
|---|---|---|---|
| Arthritis | Yes No | GI Problems (please specify) | Yes No |
| Acid Reflux(GERD) | Yes No | GYN Cancer(please specify) | Yes No |
| AIDS/HIV | Yes No | Headaches/Migraines | Yes No |
| Anemia | Yes No | Heart Problems | Yes No |
| Anxiety/Depression | Yes No | Hematologic Disorders(please specify) | Yes No |
| Asthma | Yes No | Hepatitis | Yes No |
| Bladder Disorder (please specify) | Yes No | High Cholesterol | Yes No |
| Breast Cancer | Yes No | High Blood Pressure | Yes No |
| Cancer (please specify) | Yes No | Kidney Disorder(please specify) | Yes No |
| Coronary Artery Disease | Yes No | Lung Disease(please specify) | Yes No |
| Diabetes | Yes No | Osteoporosis/Osteopenia | Yes No |
| DVT/PE | Yes No | Psychiatric Illness | Yes No |
| Endometriosis | Yes No | Stroke | Yes No |
| Glaucoma | Yes No | Thrombophilia | Yes No |
| Fibromyalgia | Yes No | Thyroid Disorder | Yes No |
| Other | | | |

**SURGICAL HISTORY – Please list any surgery you may have had in the past.**

| Type of Surgery | Date of Surgery |
|---|---|
| | |
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| | |

**FAMILY HISTORY**

**Last Name:** _____ **First Name:** _____ **Date of Birth**: _____

Mother □ Living □ Deceased - Cause and Age at death: _____

Father □ Living □ Deceased - Cause and Age at death: _____

Number of Siblings: _____ Living _____ Deceased _____ Cause _____

Has any of your blood relative(s) had the following, also specify the age and relationship:

| | Yes/No | Relative | | Yes/No | Relative |
|---|---|---|---|---|---|
| Ovarian Cancer | | | High Blood Pressure | | |
| Uterine Cancer | | | Kidney Disease | | |
| Colon Cancer | | | Hyperlipidemia | | |
| Breast Cancer | | | Diabetes | | |
| Melanoma | | | Depression | | |
| Prostate Cancer | | | Bipolar Disorder | | |
| Heart Disease | | | Stroke | | |
| Thyroid Disease | | | Osteoporosis | | |
| Other | | | | | |

**SOCIAL HISTORY**

Occupation: _____

Level of Education: _____

Marital Status: (circle one) Single Married Divorced Separated Widowed Domestic Partner

Exercise Level: (circle one) None Occasional Moderate Heavy

Smoking Status: (circle one) Never a smoker Former Smoker Smoker Have been smoking since ____years old

Alcohol Intake: (circle one) None Occasional Moderate Heavy

Do you use illicit drugs? No Yes _____

Have you ever had abuse or domestic violence directed at you: No Yes

Do you routinely use a seat belt? No Yes Do you use sunscreen regularly? No Yes

Is a blood transfusion acceptable in an emergency? No Yes

Do you have an advanced directive? No Yes