

FOR OFFICE USE ONLY

- NEW PATIENT
- ESTABLISHED PATIENT
- CONSULTATION
- REPORT SENT: / /

## PATIENT INTAKE HISTORY

PATIENT NAME:		BIRTH DATE: / /	ID NO.:	DATE: / /
ADDRESS:				
CITY:		STATE/ZIP:		
HOME TELEPHONE: (        )		WORK TELEPHONE: (        )		
EMPLOYER:		INSURANCE:	POLICY NO.:	
NAME YOU WOULD LIKE US TO USE:		PRIMARY LANGUAGE:		
NAME OF SPOUSE/PARTNER:		EMERGENCY CONTACT:		
		RELATIONSHIP:		
		HOME TELEPHONE: (        )	WORK TELEPHONE: (        )	
REFERRED BY:				
WHY HAVE YOU COME TO THE OFFICE TODAY?				
IF YOU ARE HERE FOR AN ANNUAL EXAMINATION IS THIS A <input type="checkbox"/> PRIMARY CARE VISIT OR <input type="checkbox"/> GYNECOLOGY ONLY				
IS THIS A NEW PROBLEM?				
PLEASE DESCRIBE YOUR PROBLEM, INCLUDING WHERE IT IS, HOW SEVERE IT IS, AND HOW LONG IT HAS LASTED.				

**If you are uncomfortable answering any questions, leave them blank; you can discuss them with your doctor or nurse.**

### GYNECOLOGIC HISTORY

	PHYSICIAN'S NOTES
LAST NORMAL MENSTRUAL PERIOD (FIRST DAY): / /	
AGE PERIODS BEGAN:	
LENGTH OF PERIODS (NUMBER OF DAYS OF BLEEDING):	
NUMBER OF DAYS BETWEEN PERIODS:	
ANY RECENT CHANGES IN PERIODS?	
ARE YOU CURRENTLY SEXUALLY ACTIVE?	
HAVE YOU EVER HAD SEX?	
NUMBER OF SEXUAL PARTNERS (LIFETIME):	
SEXUAL PARTNERS ARE <input type="checkbox"/> MEN <input type="checkbox"/> WOMEN <input type="checkbox"/> BOTH	
PRESENT METHOD OF BIRTH CONTROL:	
HAVE YOU EVER USED AN INTRAUTERINE DEVICE (IUD) OR BIRTH CONTROL PILLS?	
IF YES, FOR HOW LONG?	
WHEN WAS YOUR LAST PAP TEST?	
WHAT WAS THE RESULT?	
HAVE YOU EVER HAD AN ABNORMAL PAP TEST?	
DO YOU DO BREAST SELF-EXAMINATIONS?	
HAVE YOU BEEN EXPOSED TO DIETHYLSTILBESTROL (DES)?	

ACOG WOMAN'S HEALTH RECORD (FORM B—PATIENT INTAKE HISTORY) PAGE 1 OF 6

# PATIENT INTAKE HISTORY *(Continued)*

PATIENT NAME:	BIRTH DATE: / /	ID NO.:	DATE: / /
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## OBSTETRIC HISTORY

		NUMBER			NUMBER			NUMBER
PREGNANCIES			ABORTIONS			MISCARRIAGES		
PREMATURE BIRTHS (<37 WEEKS)			LIVE BIRTHS			LIVING CHILDREN		
NO.	BIRTH DATE	WEIGHT AT BIRTH	BABY'S SEX	WEEKS PREGNANT	TYPE OF DELIVERY (VAGINAL, CESAREAN, ETC.)		PHYSICIAN'S NOTES	
1.								
2.								
3.								
4.								
ANY PREGNANCY COMPLICATIONS?								
<input type="checkbox"/> DIABETES <input type="checkbox"/> HYPERTENSION/HIGH BLOOD PRESSURE <input type="checkbox"/> PREECLAMPSIA/TOXEMIA <input type="checkbox"/> OTHER								
ANY HISTORY OF DEPRESSION BEFORE OR AFTER PREGNANCY? <input type="checkbox"/> NO <input type="checkbox"/> YES, HOW TREATED								

## CURRENT MEDICATIONS

(Including hormones, vitamins, herbs, nonprescription medications)

DRUG NAME	DOSAGE	WHO PRESCRIBED	DRUG NAME	DOSAGE	WHO PRESCRIBED

## FAMILY HISTORY

MOTHER: <input type="checkbox"/> LIVING <input type="checkbox"/> DECEASED—CAUSE:		AGE:	FATHER: <input type="checkbox"/> LIVING <input type="checkbox"/> DECEASED—CAUSE:		AGE:
SIBLINGS: NUMBER LIVING:		NUMBER DECEASED:	CAUSE(S)/AGE(S):		
CHILDREN: NUMBER LIVING:		NUMBER DECEASED:	CAUSE(S)/AGE(S):		
ILLNESS	YES	WHICH RELATIVE(S) AND AGE OF ONSET		PHYSICIAN'S NOTES	
DIABETES	<input type="checkbox"/>				
STROKE	<input type="checkbox"/>				
HEART DISEASE	<input type="checkbox"/>				
BLOOD CLOTS IN LUNGS OR LEGS	<input type="checkbox"/>				
HIGH BLOOD PRESSURE	<input type="checkbox"/>				
HIGH CHOLESTEROL	<input type="checkbox"/>				
OSTEOPOROSIS [WEAK BONES]	<input type="checkbox"/>				
HEPATITIS	<input type="checkbox"/>				
HIV/AIDS	<input type="checkbox"/>				
TUBERCULOSIS	<input type="checkbox"/>				
BIRTH DEFECTS	<input type="checkbox"/>				
ALCOHOL OR DRUG PROBLEMS	<input type="checkbox"/>				
BREAST CANCER	<input type="checkbox"/>				
COLON CANCER	<input type="checkbox"/>				
OVARIAN CANCER	<input type="checkbox"/>				
UTERINE CANCER	<input type="checkbox"/>				
MENTAL ILLNESS/DEPRESSION	<input type="checkbox"/>				
ALZHEIMER'S DISEASE	<input type="checkbox"/>				
OTHER	<input type="checkbox"/>				

# PATIENT INTAKE HISTORY (Continued)

PATIENT NAME:	BIRTH DATE: / /	ID NO.:	DATE: / /
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## SOCIAL HISTORY

	YES	NO	PHYSICIAN'S NOTES
EVER SMOKED? CURRENT SMOKING: PACKS PER DAY: YEARS:	<input type="checkbox"/>	<input type="checkbox"/>	
ALCOHOL: DRINKS PER DAY: DRINKS PER WEEK: TYPE OF DRINK:	<input type="checkbox"/>	<input type="checkbox"/>	
DRUG USE	<input type="checkbox"/>	<input type="checkbox"/>	
SEAT BELT USE	<input type="checkbox"/>	<input type="checkbox"/>	
REGULAR EXERCISE: HOW LONG AND HOW OFTEN?	<input type="checkbox"/>	<input type="checkbox"/>	
DAIRY PRODUCT INTAKE AND/OR CALCIUM SUPPLEMENTS: DAILY INTAKE:	<input type="checkbox"/>	<input type="checkbox"/>	
HEALTH HAZARDS AT HOME OR WORK?	<input type="checkbox"/>	<input type="checkbox"/>	
HAVE YOU BEEN SEXUALLY ABUSED, THREATENED, OR HURT BY ANYONE?	<input type="checkbox"/>	<input type="checkbox"/>	
DO YOU HAVE AN ADVANCE DIRECTIVE (LIVING WILL)?	<input type="checkbox"/>	<input type="checkbox"/>	
ARE YOU AN ORGAN DONOR?	<input type="checkbox"/>	<input type="checkbox"/>	

## PERSONAL PROFILE

SEXUAL ORIENTATION: <input type="checkbox"/> HETEROSEXUAL <input type="checkbox"/> HOMOSEXUAL <input type="checkbox"/> BISEXUAL	
MARITAL STATUS: <input type="checkbox"/> MARRIED <input type="checkbox"/> LIVING WITH PARTNER <input type="checkbox"/> SINGLE <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	
NUMBER OF LIVING CHILDREN:	
NUMBER OF PEOPLE IN HOUSEHOLD:	
SCHOOL COMPLETED: <input type="checkbox"/> HIGH SCHOOL <input type="checkbox"/> SOME COLLEGE/AA DEGREE <input type="checkbox"/> COLLEGE <input type="checkbox"/> GRADUATE DEGREE <input type="checkbox"/> OTHER	
CURRENT OR MOST RECENT JOB:	
TRAVEL OUTSIDE THE UNITED STATES?	LOCATION(S):

## PERSONAL PAST HISTORY OF ILLNESSES

MAJOR ILLNESSES	YES (DATE)	NO	NOT SURE	PHYSICIAN'S NOTES
ASTHMA				
PNEUMONIA/LUNG DISEASE				
KIDNEY INFECTIONS/STONES				
TUBERCULOSIS				
FIBROIDS				
SEXUALLY TRANSMITTED DISEASE/CHLAMYDIA				
INFERTILITY				
HIV/AIDS				
HEART ATTACK/DISEASE				
DIABETES				
HIGH BLOOD PRESSURE				
STROKE				
RHEUMATIC FEVER				
BLOOD CLOTS IN LUNGS OR LEGS				
EATING DISORDERS				
AUTOIMMUNE DISEASE (LUPUS)				
CHICKENPOX				
CANCER				
REFLUX/HIATAL HERNIA/ULCERS				
DEPRESSION/ANXIETY				
ANEMIA				
BLOOD TRANSFUSIONS				
SEIZURES/CONVULSIONS/EPILEPSY				
BOWEL PROBLEMS				
GLAUCOMA				
CATARACTS				
ARTHRITIS/JOINT PAIN/BACK PROBLEMS				
BROKEN BONES				
HEPATITIS/YELLOW JAUNDICE/LIVER DISEASE				
THYROID DISEASE				

# PATIENT INTAKE HISTORY *(Continued)*

PATIENT NAME:	BIRTH DATE: / /	ID NO.:	DATE: / /
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## PERSONAL PAST HISTORY OF ILLNESSES *(Continued)*

MAJOR ILLNESSES	YES (DATE)	NO	NOT SURE	PHYSICIAN'S NOTES
GALLBLADDER DISEASE				
HEADACHES				
DES EXPOSURE				
INFERTILITY				
BLEEDING DISORDERS				
OTHER				

## OPERATIONS/HOSPITALIZATIONS

REASON	DATE	HOSPITAL

## INJURIES/ILLNESSES

TYPE	DATE	TYPE	DATE

## IMMUNIZATIONS/TEST

	DATE		DATE
TETANUS-DIPHTHERIA BOOSTER		INFLUENZA VACCINE (FLU SHOT)	
HEPATITIS A VACCINE		HEPATITIS B VACCINE	
VARICELLA (CHICKENPOX) VACCINE		PNEUMOCOCCAL (PNEUMONIA) VACCINE	
MEASLES-MUMPS-RUBELLA (MMR) VACCINE		TUBERCULOSIS (TB) SKIN TEST: RESULT:	

**PHYSICIAN'S NOTES:**


## REVIEW OF SYSTEMS

Please check (x) if any of the following symptoms apply to you now or since adulthood

	NOW	PAST	NOT SURE	PHYSICIAN'S NOTES
<b>1. CONSTITUTIONAL</b>				
WEIGHT LOSS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
WEIGHT GAIN	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
FEVER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
FATIGUE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
CHANGE IN HEIGHT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

# PATIENT INTAKE HISTORY *(Continued)*

PATIENT NAME:	BIRTH DATE: / /	ID NO.:	DATE: / /
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## REVIEW OF SYSTEMS *(Continued)*

	NOW	PAST	NOT SURE	PHYSICIAN'S NOTES
<b>2. EYES</b>				
DOUBLE VISION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
SPTS BEFORE EYES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
VISION CHANGES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
GLASSES/CONTACTS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>3. EAR, NOSE, AND THROAT</b>				
EARACHES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
RINGING IN EARS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
HEARING PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
SINUS PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
SORE THROAT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
MOUTH SORES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
DENTAL PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>4. CARDIOVASCULAR</b>				
CHEST PAIN OR PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
DIFFICULTY BREATHING ON EXERTION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
SWELLING OF LEGS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
RAPID OR IRREGULAR HEARTBEAT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>5. RESPIRATORY</b>				
PAINFUL BREATHING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
WHEEZING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
SPITTING UP BLOOD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
SHORTNESS OF BREATH	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
CHRONIC COUGH	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>6. GASTROINTESTINAL</b>				
FREQUENT DIARRHEA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
BLOODY STOOL	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
NAUSEA/VOMITING/INDIGESTION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
CONSTIPATION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
INVOLUNTARY LOSS OF GAS OR STOOL	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>7. GENITOURINARY</b>				
BLOOD IN URINE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
PAIN WITH URINATION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
STRONG URGENCY TO URINATE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
FREQUENT URINATION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
INCOMPLETE EMPTYING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
INVOLUNTARY/UNINTENDED URINE LOSS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
URINE LOSS WHEN COUGHING OR LIFTING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
ABNORMAL BLEEDING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
PAINFUL PERIODS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
PREMENSTRUAL SYNDROME (PMS)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
PAINFUL INTERCOURSE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
ABNORMAL VAGINAL DISCHARGE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>8. MUSCULOSKELETAL</b>				
MUSCLE WEAKNESS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

# PATIENT INTAKE HISTORY *(Continued)*

PATIENT NAME:	BIRTH DATE: / /	ID NO.:	DATE: / /
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## REVIEW OF SYSTEMS *(Continued)*

	NOW	PAST	NOT SURE	PHYSICIAN'S NOTES
<b>8. MUSCULOSKELETAL</b> <i>(Continued)</i>				
MUSCLE OR JOINT PAIN	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>9a. SKIN</b>				
RASH	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
SORES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
DRY SKIN	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
MOLES (GROWTH OR CHANGES)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>9b. BREASTS</b>				
PAIN IN BREAST	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
NIPPLE DISCHARGE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
LUMPS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>10. NEUROLOGIC</b>				
DIZZINESS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
SEIZURES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
NUMBNESS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
TROUBLE WALKING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
MEMORY PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
FREQUENT HEADACHES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>11. PSYCHIATRIC</b>				
DEPRESSION OR FREQUENT CRYING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
ANXIETY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>12. ENDOCRINE</b>				
HAIR LOSS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
HEAT/COLD INTOLERANCE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
ABNORMAL THIRST	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
HOT FLASHES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>13. HEMATOLOGIC/LYMPHATIC</b>				
FREQUENT BRUISES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
CUTS DO NOT STOP BLEEDING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
ENLARGED LYMPH NODES (GLANDS)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>14. ALLERGIC/IMMUNOLOGIC</b>				
MEDICATION ALLERGIES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
IF ANY, PLEASE LIST ALLERGY AND TYPE OF REACTION:				
LATEX ALLERGY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
OTHER ALLERGIES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
PLEASE LIST ALLERGY AND TYPE OF REACTION:				

FORM COMPLETED BY:  PATIENT  OFFICE NURSE  PHYSICIAN  OTHER:

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: _____
DATE REVIEWED: / /	PHYSICIAN SIGNATURE: _____
DATE REVIEWED: / /	PHYSICIAN SIGNATURE: _____