GENESIS OB/GYN

HEALTH INTAKE FORM
(Please Print)

Name: D.O.B:

PAST MEDICAL HISTORY

PAST MEDICAL HISTORY
DIAGNOSIS

1. If you have been hospitalized or had surgery in the past, please complete the chart below:

HOSPITALIZATIONS/SURGERIES (Please write in decreasing chronological order)	
YEAR	TYPE OF SURGERY/REASON FOR VISIT

2. Please complete the charts below if applicable. If you already have a list please give it to the receptionist.

PLEASE LIST ANY PRESCRIBED OR OVER-THE-COUNTER MEDICATIONS YOU ARE CURRENTLY TAKING (Please include vitamins, herbs, inhalers, and aspirin)		
NAME	DOSAGE	FREQUENCY TAKEN

Date:

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PLEASE LIST ANY ALLERGIES YOU HAVE	
DRUG ALLERGY/FOOD ALLERGY	DESCRIBE REACTION

OBSTETRICAL HISTORY

DELIVERY HISTORY (Please put in decreasing chronological order)					
YEAR	WEEKS GESTATION	Type of delivery (Vaginal or Cesarean)	Place of Birth/Hospital	Birth weight	Complications

Date:

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MISCARRIAGES/ABORTIONS		
YEAR	WEEKS	D&E

PREVENTION

3. First day of last menstrual period _____
4. Date of Last Pap Smear _____
   i. Result? _____
   ii. Have you ever had an abnormal pap smear?
      ☐ Yes ☐ No
   iii. If Yes, when? _____
5. Have you ever had a DEXA (bone density) scan?
      ☐ Yes ☐ No
   i. Date? _____
   ii. Result? _____
6. Mammograms
   i. Date of last mammogram _____
      ☐ Normal ☐ Result _____
      ☐ Abnormal
   ii. Do you perform monthly self breast exams?
      ☐ Yes ☐ No
   iii. Do you have a family history of Breast Cancer?
      ☐ If Yes, please complete below:
         a. Family member with breast cancer _____
      ☐ No

   iv. Have you ever had a breast biopsy?
      ☐ If Yes, please complete below:
         b. Result _____
      ☐ No

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7. Have you had a colonoscopy?
   - ☐ If Yes, please complete below:
     a. Date _____
     b. Result_____
   - ☐ No

8. Have you had a hysterectomy?
   - ☐ If Yes, please complete below:
     a. When?
     b. Were both ovaries removed?
        - ☐ Yes
        - ☐ No
   - ☐ No

9. Hormone Replacement Therapy (HRT)
   a. Are you currently taking Hormone Replacement Therapy (HRT)?
      ☐ Yes ☐ No
   b. Have you ever taken HRT?
      - ☐ If Yes, how long? _____
      - ☐ No

10. Are you menopausal and/or over age 50?
    - ☐ If Yes, please complete below:
      a. At what age were you menopausal? _____
    - ☐ No

SOCIAL HISTORY

11. Marital Status:
    ☐ Single ☐ Married ☐ Widowed
    ☐ Partnered ☐ Divorced

12. Place of birth _____

13. Current occupation _____

14. Have you <u>ever</u> used tobacco?
    - ☐ If Yes, please complete below:
      a. Current Use
         i. Average number of packs/day: _____
         ii. Total number of years smoked: _____
      b. Past Use
         iii. Total number of years used: _____
         iv. Year quit: _____
    - ☐ No

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15. Have you ever used drugs?
    - ☐ If Yes, please complete below:
        a. If so, what kind: _____
    - ☐ No

16. Do you currently drink alcohol?
    - ☐ If Yes, how much? _____
    - ☐ No

17. Caffeine Use. Check all that apply:
    - ☐ None
    - ☐ Coffee
    - ☐ Tea
    - ☐ Soda
    a. How much per day? _____

18. Do you exercise regularly?
    - ☐ If Yes, please complete below
        a. What type of exercise _____
    - ☐ No

SEX

19. Are you sexually active?
    - ☐ Yes
    - ☐ No

20. Are you planning to get pregnant in the near future?
    - ☐ Yes
    - ☐ No

21. Have you been unable to get pregnant within the past year?
    - ☐ Yes
    - ☐ No

22. Are you using any birth control?
    - ☐ If Yes, please complete below:
        a. What method of birth control do you use? _____
        b. If pills, which brand? _____
    - ☐ No

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Name: D.O.B:

FAMILY HISTORY

FAMILY HEALTH HISTORY					
	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
FATHER				☐ F ☐ M	
MOTHER				☐ F ☐ M	
AUNTS			**CHILDREN**	☐ F ☐ M	
UNCLES				☐ F ☐ M	
SIBLINGS	☐ F ☐ M			☐ F ☐ M	
	☐ F ☐ M			☐ F ☐ M	
	☐ F ☐ M		**Grandmother** *MATERNAL*		
	☐ F ☐ M		**Grandfather** *MATERNAL*		
	☐ F ☐ M		**Grandmother** *PATERNAL*		
	☐ F ☐ M		**Grandfather** *PATERNAL*		

21. If any of your immediate family members have suffered from cancer, please check all that apply:

☐ Ovarian ☐ Uterine ☐ OTHER _____
☐ Colon ☐ Breast

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HEALTH INTAKE FORM
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Name: D.O.B:

Review of Symptoms:

GENERAL	CURRENT	PAST
Fatigue		
Night sweats		
Fever		
Chills		
SKIN	CURRENT	PAST
Itching		
Rash		
Acne		
Change in wart/mole		
HEENT	CURRENT	PAST
Visual disturbances/changes		
Eye Irritation		
Blurred vision		
Glasses/contacts		
Decreased hearing		
Difficulty hearing		
Ringing in ears		
Sore throat		
Hoarseness		
Bleeding gums		
Mouth ulcers		
Cavities		
NECK	CURRENT	PAST
Pain		
Stiffness		
Swelling glands		
RESPIRATORY	CURRENT	PAST
Sinus pain		
Runny nose		
Persistent cough		
Trouble breathing		
Rhinitis		

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Shortness of breath		
Easily fatigued		
Wheezing		
Nasal congestion		
Seasonal Allergy		
Sputum production		
Snoring		
Coughing up blood		
BREAST	CURRENT	PAST
Mass/lumps		
Pain		
Swelling		
Nipple discharge		
Nipple pain		
Skin changes		
CARDIOVASCULAR	CURRENT	PAST
Chest pain		
Palpitations		
GASTROINTESTINAL	CURRENT	PAST
Abdominal pain		
Gas pain		
Vomiting blood		
Difficulty swallowing		
Nausea		
Vomiting		
Change in appetite		
Heartburn or indigestion		
Diarrhea		
Constipation		
Abdominal pain		
Change in bowel habits		
Black or bloody bowel movements		
Hemorrhoids		
Loss of bowel control		
HEMATOLOGIC/LYMPHATIC	CURRENT	PAST
Anemia		
Easy bleeding		

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Abnormal Bruising		
Enlarged Glands		
Blood clots		
Nose bleeds		
Blood Transfusion (if yes, please include year)		
MUSCULOSKELETAL	CURRENT	PAST
Back pain		
Joint swelling		
Joint pain		
Muscle weakness		
Edema		
Muscle pain		
NEUROLOGICAL	CURRENT	PAST
Headache		
Fainting		
Loss of feeling/Power limbs or face [Please specify arm, leg, face (R/L)]		
Numbness		
Aura		
Dizziness		
Seizures		
Stroke		
Memory loss		
Tremor		
Vertigo		
Dizziness		
PSYCHOLOGICAL	CURRENT	PAST
Anxiety		
Depression		
Tension		
Stress		
Insomnia		
Hallucinations		
Hyper insomnia		
Frequent crying		
Panic attacks		
Mood change		
Restless dreams		
GENTOURINARY	CURRENT	PAST
Vaginal dryness		
Vaginal itching		
Painful intercourse		
Decreased/absent sexual drive		
Painful periods		
Heavy periods		

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Irregular periods		
Postmenopausal bleeding		
Pelvic pain		
Difficulty urinating		
Frequent urinating		
Leakage of urine with cough, sneezing, or laughing		
Uncontrollable loss of urine		
Pelvic pressure		
Blood in urine		
Urinary tract infections		
Urinary incontinency		
Kidney stones		
ALLERGIC/IMMUNOLOGIC	CURRENT	PAST
Hay Fever		
Itching		
HIV Exposure		

22. Please describe any concerns you may have:

_____

_____

_____

_____

Date: