Rue de Santé
Women's Center
Obstetrics & Gynecology

Gynecologic Intake History

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Name: ______________________ Date: ______ / ______ / ______

Address: ______________________ Birth Day ______ / ______ / ______

City: ______________________ Home Tel: ( ) ______________________

State ______________________ Work Tel: ( ) ______________________

Zip: ______________________ Cell Tel: ( ) ______________________

Employer: ______________________ Insurance: ______________________

Name of Spouse / Partner ______________________ Referred by: ______________________

REVIEW OF SYSTEMS: 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 thoat	☐	☐	
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 unrination	☐	☐	
Urgency	☐	☐	
Frequency of urination	☐	☐	
Incomplete emptying	☐	☐	
Stress incontenece	☐	☐	
Abnormal periods	☐	☐	
Painful intercourse	☐	☐	
8. Musculoskeletal			
Muscle weakness	☐	☐	
9. Skin / Breast			
Pain in breast	☐	☐	
Discharge	☐	☐	
Masses	☐	☐	
Rash	☐	☐	
Ulcers	☐	☐	

REVIEW OF SYSTEMS (CONTINUED): Please check (√) appropriate box if any of the following apply to you now or have applied in the past

	Currently	Past	
10. Neuroligical			
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	☐	☐
Venerial disease	☐	☐	Bowel trouble	☐	☐
Heart trouble / murmur	☐	☐	Glaucoma	☐	☐
Diabetes	☐	☐	Arthritis / joint paint	☐	☐
High blood pressure	☐	☐	Fracture	☐	☐
Stroke	☐	☐	Hepatitis / yellow jaundice	☐	☐
Rheumatic fever	☐	☐	Thyroid disease	☐	☐

Operations / Hospitalizations (Describe reason for operation / hospitialization)

	Date		Date

Injuries / illnesses (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	☐	☐	Packs per day: ______________	Years: ______________
Alcohol	☐	☐	Drinks per day: ______________	Drinks per week: ______________
Drug use	☐	☐		
Seat belt use	☐	☐		
Regular exercise	☐	☐		

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:

Has anyone close to you ever threatened to hurt you?	☐ Yes	☐ No
Has anyone ever hit, kicked, choked or hurt you physically?	☐ Yes	☐ No
Has anyone, including your partner, ever forced you to have sex?	☐ Yes	☐ No
Are you ever afraid of your partner?	☐ Yes	☐ No

MEDICARE "HIGH RISK" CRITERIA: Please check (√) if you have ever been treated for any of the following infections:

☐ Viginosis ☐ Genital Warts ☐ Chlamydia

☐ Trichomonas ☐ Gonorrhea ☐ Syphilis

Have you had a Pap smear in the last 7 years?	☐ Yes	☐ No	
Have you ever had an abnormal Pap smear test?	☐ Yes	☐ No	If so when? ______________
Did you begin having sexual activity before you were 16 years old?	☐ Yes	☐ No	
Have you had more than 5 sexual partners in your life?	☐ Yes	☐ No	
Have you ever tested positive for the HIV virus?	☐ Yes	☐ No	
Did your mother take the drug DES when she was pregnant with you?	☐ Yes	☐ No	

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: ______________

Date reviewed: ______________ Physician Signature: ______________