Gynecology Intake Form

Welcome to HER GYN , LLC

Please take a few minutes to tell us about yourself and your medical history so that we may provide you with the best care possible. Please be sure to complete this form to the best of your knowledge. If you have any questions, don't hesitate to ask for assistance from us.

Patient Name: _____ Date: ____/____/____

Height:_____ Weight: _____ Age:_____

What brings you to our office today: _____

_____

CURRENT MEDICATIONS

DRUG NAME	DOSE	DRUG NAME	DOSE

ALLERGIES

List drug, environmental, and food allergies	Reaction

GYN HISTORY

What is the first day of your last menstrual period? _____

How long did it last? _____

Do you have heavy periods? ☐ Yes ☐ No

When was your last pap smear? _____ What was the result? _____

Have you ever had an abnormal pap? ☐ Yes ☐ No

If so, when? _____ What was the abnormality? _____

Have you ever had the following:

☐ Colposcopy - Date:___/___/___ ☐ Cryosurgery - Date: ___/___/___ ☐LEEP - Date: ___/___/___

☐Last Mammogram - Date: ___/___/___

OB/GYN HISTORY

	NUMBER		NUMBER
Birth(s)		Abortion(s)	
Miscarriage(s)		Living Children	

Delivery Date	Birth Weight	Sex of Baby	Vaginal/C-sec	Anesthesia	Name of Baby	Hospital/City

OPERATIONS / HOSPITALIZATIONS

Hospitalization	Date	Operation	Date

FAMILY HISTORY

Illness	Yes	No	Family Member	Age of Diagnosis
Diabetes				
Stroke				
Heart Disease				
Hypertension				
Drinking Problem				
Breast Cancer				
Cancer ☐ovarian ☐colon ☐other				

☐ I AM ADOPTED

SOCIAL HISTORY

Personal Habits	Current	Former	Never	Notes
Alcohol				# drinks per week: # drinks per day:
Drug Use				
Tobacco				# packs per day: Age started: Age quit:
Seat Belt Use				
Regular Exercise				Type of exercise:

PERSONAL PROFILE

Marital Status: ☐single ☐dating ☐engaged ☐married ☐widowed ☐divorced
Do you have sex with: ☐Men ☐Women ☐Both
Number of Living Children: Number of people in household:
Highest Education level completed: ☐high school ☐college ☐graduate / studies degree ☐other _____
Current Job:

PERSONAL SAFETY

	Yes	No
Has anyone close to you ever threatened to hurt you?		
Has anyone ever hit, kicked, choked, or hurt you physically?		
Has anyone, including your partner, ever forced you to have sex?		
Are you afraid of your partner?		
Please check off any of the following you have been treated for: ☐vaginosis ☐genital warts ☐chlamydia ☐trichomoniasis ☐gonorrhea ☐syphilis		
	Yes	No
Did you begin sexual activity before you were 18 years old?		
Are you currently sexually active? ☐never		
Have you had more than 5 sexual partners		
Are you currently using birth control? If yes, method of birth control _____		
Have you ever tested ***POSITIVE*** for the ***HIV*** virus (the human immunodeficiency virus)		
Did your mother take the drug DES when was pregnant with you		
Have you received the HPV vaccine? (Gardasil)		

REVIEW OF SYSTEMS

Check all of the conditions that you are CURRENTLY having. Include ONLY present conditions.

Condition	Yes	Notes	Condition	Yes	Notes
Fever			Blood in Urine		
Fatigue			Pain with urination		
Weight loss			Urinary Frequency		
Weight gain			Urinary Urgency		
Vision problems			Incomplete empty		
Sore throat			Stress Incontinence		
Sinus problems			Abnormal Periods		
Chest pain			Painful Intercourse		
Difficulty breathing			Muscle Weakness		
Swelling of legs			Pain in Breast		
Heart Palpitations			Breast Discharge		
Wheezing			Breast Masses		
Coughing blood			Breast Rash		
Shortness of breath			Dizziness		
Chronic Cough			Seizures		
Frequent Diarrhea			Numbness		
Blood in Stool			Difficulty Walking		
Nausea			Depression		
Vomiting			Anxiety		
Constipation			Dry Skin		
Frequent Bruising			Abnormal Thirst		
Enlarged Glands			Hot Flashes		

PAST PERSONAL HISTORY

Yes		Yes		Yes	
	Asthma		Cancer		Fibroids
	Pneumonia		Ulcers		Endometriosis
	Chronic Lung Disease		Depression/ Anxiety		Ovarian Cyst
	Kidney Infection/ Stones		Anemia / Blood Transfusions		Osteopenia
	Tuberculosis		Seizures/ Epilepsy		Osteoporosis
	Venereal Disease		Bowel Trouble		GI Disease
	Heart Trouble/ Murmur		Glaucoma		GI Reflux
	Diabetes		Arthritis		Heart Disease
	High Blood Pressure		Fracture		Clotting Disorder
	Stroke		Hepatitis/ Yellow Jaundice		Other:
	Rheumatic Fever		Thyroid Disease		

Completed by: ☐Patient ☐Nurse ☐Physician

Signature of Patient _____