PATIENT INTAKE HISTORY

Patient Name	Date of Birth	Date
Address		
City:	State/Zip	
Home Telephone :	Work Telephone:	
Cellular Telephone:		
Employer:		
Insurance Company	Policy #	Group #
Insurance Co Telephone	Guarantor Name	
Guarantor Date of Birth	Guarantor SS#	
Name of Spouse/Partner	Emergency Contact Name	
Referred By:	Relationship	
How did you hear about us? Home Telephone		Work Telephone
Please describe your current medical problem, including where it is, how severe it is and how long it has lasted.		

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

Gynecologic History

	Physician's Notes
Last Normal Menstrual period (First Day): / /	
Age Period began:	
Length of periods (Number of days 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 ☐ men ☐ women ☐ both	
Present method of birth control?	
Have you ever used an intruauterine 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)?	

PATIENT INTAKE HISTORY (Continued)

Patient Name Date of Birth Date

Obstetric History

		Number		Number		Number
Pregnancies			Abortions		Miscarriages	
Premature Births (<37 wks)			Live Births		Living children	
No.	Date of Birth	Weight at Birth	Baby's Sex	Wks Pregnant	Type of Delivery (Vaginal, cesarean, etc.)	Physician's Notes
1.						
2.						
3.						
4.						
5.						

Any pregnancy complications?

☐ Diabetes ☐ Hypertension/High Blood Pressure ☐ Pre-eclampsia/Toxemia ☐ Other

Any history of depression before or after pregnancy? ☐ No ☐ Yes, How treated

Current Medications

(Including hormones, vitamins, herbs, nonprescription medications)

Drug Name	Dosage	Who Prescribed	Drug Name	Dosage	Who Prescribed

Family History

Mother: Living	Deceased-Cause:	Age:	Father: Living	Deceased-Cause:	Age:
Siblings: # Living	# Deceased-Cause:	Ages:	Children: # Living	# Deceased-Cause:	Ages:

Illness	**Yes**	**Which Relative(s) and age of onset**	**Physician's Notes**
Diabetes	☐		
Stroke	☐		
Heart Disease	☐		
Blood Clots in lungs or legs	☐		
High blood pressure	☐		
High cholesterol	☐		
Osteoporosis (weak bones)	☐		
Hepatitis	☐		
HIV/AIDS	☐		
Tuberculosis	☐		
Birth Defects	☐		
Alcohol or drug problems	☐		
Breast cancer	☐		
Colon cancer	☐		
Ovarian cancer	☐		
Uterine cancer	☐		
Mental illness/depression	☐		
Alzheimer's disease	☐		
Other	☐		

Patient Name Birthday ID No: Date

Social History

	Yes	No	Physician's Notes
Ever Smoked? Current Smoking: Packs per day: _____ Years: _____	☐	☐	
Alcohol Drinks per day: ____ Drinks per week: _____ Types of Drink: _____	☐	☐	
Drug Use	☐	☐	
Seat Belt Use	☐	☐	
Regular Exercise: How long and how often?	☐	☐	
Dairy Product intake and/or Calcium supplements: Daily Intake: _____	☐	☐	
Health hazards at home or work?	☐	☐	
Have you been sexually abused, threatened, or hurt my anyone?	☐	☐	
Do you have an advance directive (living will)?	☐	☐	
Are you an organ donor?	☐	☐	

Personal Profile

Past Medical History and Review of Systems Check any or all that apply to you whether you are experiencing now or have ever

☐ High Blood Pressure	☐ Swollen Ankles	☐ Bronchitis	☐ Indigestion	☐ Ulcer
☐ Diabetes	☐ Palpitations	☐ Pneumonia	☐ Nausea	☐ Colitis
☐ Cancer	☐ Persistent Cough	☐ Lightheaded	☐ Vomiting	☐ Arthritis
☐ Heart Disease	☐ Frequent urination	☐ T.B.	☐ Constipation	☐ Anxiety
☐ Chest pain	☐ Rheumatic fever	☐ Hay Fever	☐ Diarrhea	☐ Depression
☐ Shortness of breath	☐ Asthma	☐ Abdominal discomfort	☐ Blood in Stool	☐ Anemia
☐ Headache	☐ Kidney disease	☐ Gall Bladder disease	☐ Alcohol Abuse	☐ Change in Bowel Habits
☐ Unexplained wt gain	☐ Kidney Stones	☐ Hepatitis or Jaundice	☐ Thyroid Disease	☐ Drug Abuse
☐ Blood disorders	☐ Difficulty urinating	☐ Hemorrhoids	☐ Skin Diseases	☐ Low Back Problems

☐ Other _____

When was your last:

☐ Pap Smear _____ ☐ Cholesterol check _____

☐ Mammogram _____ ☐ Colon Cancer Test _____

☐ Breast Exam _____ ☐ Prostate exam _____

☐ Physical _____

Hospitalization/Surgeries

☐ None

_____

_____

_____

Immunizations: (Check all that apply and date)

Hepatitis B ☐ _____ ☐ Tetanus _____ ☐ Other _____

Pnemovax ☐ _____ ☐ Other _____

Influenza ☐ _____ _____

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

☐ High Blood Pressure	☐ Swollen Ankles	☐ Bronchitis	☐ Indigestion	☐ Ulcer
☐ Diabetes	☐ Palpitations	☐ Pneumonia	☐ Nausea	☐ Colitis
☐ Cancer	☐ Persistent Cough	☐ Lightheaded	☐ Vomiting	☐ Arthritis
☐ Heart Disease	☐ Frequent urination	☐ T.B.	☐ Constipation	☐ Anxiety
☐ Chest pain	☐ Rheumatic fever	☐ Hay Fever	☐ Diarrhea	☐ Depression
☐ Shortness of breath	☐ Asthma	☐ Abdominal discomfort	☐ Blood in Stool	☐ Anemia
☐ Headache	☐ Kidney disease	☐ Gall Bladder disease	☐ Alcohol Abuse	☐ Change in Bowel Habits
☐ Unexplained wt gain	☐ Kidney Stones	☐ Hepatitis or Jaundice	☐ Thyroid Disease	☐ Drug Abuse
☐ Blood disorders	☐ Difficulty urinating	☐ Hemorrhoids	☐ Skin Diseases	☐ Low Back Problems

☐ Other _____