The Women's Centre for Well Being

GYNECOLOGIC INTAKE HISTORY

Date:_____/_____/_____

Birthdate:____/____/____

SS#:_____

Name: _____ State/Zip:_____

Address:_____ Email Address: _____

City: _____ Cell:_____

Home Tel: ( ) _____ Work Tel: ( ) _____

Employer:_____ Insurance:_____

Name of Spouse/Partner: _____ Referred By: _____

Review of Systems

Please check (x) if any of the following apply to you now, in the past or often

	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 throat	☐	☐	
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	☐	☐	
Cough, chronic	☐	☐	
6. Gastrointestinal			
Diarrhea, frequent	☐	☐	
Bloody stool	☐	☐	
Nausea/vomiting	☐	☐	
Constipation	☐	☐	
7. Genitourinary			
Blood in urine	☐	☐	
Pain with urination	☐	☐	
Urgency	☐	☐	
Frequency of urination	☐	☐	
Incomplete emptying	☐	☐	
Stress incontinence	☐	☐	
Abnormal periods	☐	☐	
Painful intercourse	☐	☐	
8. Musculoskeletal			
Muscle weakness	☐	☐	

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Please check (x) if any of the following apply to you now, in the past or often			
9. Skin/Breast	**Currently**	**Past**	**Notes**
Pain in breast	☐	☐	
Discharge	☐	☐	
Masses	☐	☐	
Rash	☐	☐	
Ulcers	☐	☐	
10. Neurological			
Dizziness	☐	☐	
Seizures	☐	☐	
Numbness	☐	☐	
Trouble walking	☐	☐	
11. Psychiatric			
Depression	☐	☐	
Crying, frequent	☐	☐	
12. Endocrine			
Dry skin	☐	☐	
Abnormal thirst	☐	☐	
Hot flashes	☐	☐	
13. Hematologic/Lymphatic			
Bruises, frequent	☐	☐	
Cuts do not stop bleeding	☐	☐	
Enlarged lymph nodes	☐	☐	
14. Allergic/Immunologic			
Allergies	☐	☐	
Drugs, other	☐	☐	

Personal Past History

Major Illnesses	Yes	No		Yes	No
Asthma			Cancer		
Pneumonia			Ulcers		
Chronic Lung Disease			Depression/anxiety		
Kidney Infections/stones			Anemia/Blood transfusions		
Tuberculosis			Seizures/convulsions/epilepsy		
Venereal Disease			Bowel trouble		
Heart Trouble/murmur			Glaucoma		
Diabetes			Arthritis/joint pain		
High Blood Pressure			Fracture		
Stroke			Hepatitis/Yellow jaundice		
Rheumatic Fever			Thyroid Disease		

Operations/Hospitalizations

Reason	Date	Reason	Date

Injuries/Illnesses

Type	Date	Type	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			
Drug Name	Dosage	Drug Name	Dosage

Family History

Illness	Yes	Relative	Illness	Yes	Relative
Diabetes			Drinking Problem		
Stroke			Breast Cancer		
Heart Disease			Colon Cancer		
High Blood Pressure			Ovarian Cancer		

Social History

Habits				
Smoking	Yes ☐	No ☐	Packs per day_____	Years_____
Alcohol	Yes ☐	No ☐	Drinks per day_____	Drinks per week_____
Drug Use	Yes ☐	No ☐		
Seat Belt Use	Yes ☐	No ☐		
Regular Exercise	Yes ☐	No ☐		

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_____

Completed by: Patient ☐ Office Nurse ☐ Physician ☐ Family Member/Friend ☐

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:_____