

Gyn Intake

Name: _____

Today's Date: _____

Address: _____

Health Insurance: _____

Birth Date: _____ Age: _____

Telephone # (where you can be contacted): _____

Email: _____

Reason for this visit: _____

Past Medical History/Family Medical History

Please check if you or your family has/had any of the following:

<u>Medical History</u>	<u>You</u>	<u>Family</u>	<u>Explanation</u>
Frequent headache or migraine			
Seizure disorder			
High cholesterol			
High blood pressure			
Heart condition or heart attack			
Blood clots, stroke, or varicose veins			
Lung disease, asthma			
Jaundice, liver problems			
Stomach, bowel, or gallbladder problems			
Breast problems			
Pelvic or vaginal infections			
Sexually transmitted infections, including herpes and warts			
DES exposure			
Cancer			
Diabetes			
Thyroid problems			
Anemia or blood disorders			
Mononucleosis			
Sickle cell disease			
Blood transfusions			
Birth or inherited diseases			
Severe mood changes preceding period			
Mental or nervous problems			

Have you ever been hospitalized? Y N Explain: _____

Do you have any medical problems not mentioned? Y N

Explain: _____

Allergies to medications: _____

Medications currently taking (including birth control pills, over the counter medications): _____

Family History:

<u>Family member</u>	<u>Alive?</u>	<u>Deceased?</u>	<u>Age?</u> <u>(or age at death)</u>	<u>Health problems</u>
Mother				
Father				
Siblings				
Brother				
Sister				
Mother's mother				
Mother's father				
Father's mother				
Father's father				

OB/GYN History:

Are you using hormonal contraceptives (i.e. birth control, nuvaring, mirena)? Y N

If yes, what kind: _____ **What was the first day of your last period?** _____

Is your period regular (every 25-35 days)? Y N Has your period always been regular? Y N

How many days does your period last? _____ Is this your first pelvic exam? Y N

Is your menstrual cycle flow: Light _____ Moderate: _____ Heavy: _____

How old were you when you first got your period? _____

Date of last pelvic exam? _____ Where: _____

Date of last Pap Smear? _____ Where: _____

Was it normal: Y N Results: _____

Have you **ever** had an abnormal pap smear? Y N

pregnancies: _____ # born children: _____ #abortions : _____ # miscarriages: _____

Do you have a history of having recurrent yeast infections, bacterial vaginosis, or UTI's? Y N

Contraceptive Use:

What form of protection and/or contraception do you currently use (if applicable)?

What have you used in the past?:

Oral contraceptives? Y N	Type: _____	
_____ Foam, jelly, cream	_____ Condoms	_____ Diaphragm
_____ Sponge	_____ Withdrawal	_____ IUD
_____ Tubal ligation	_____ Cervical Cap	_____ Natural methods
_____ Vaginal Suppositories	_____ Vaginal film	_____ No method

Problems with any of the above methods? _____

Sexual History:

Currently sexually active? Y N With: Men Women Both

Number of current partners?: _____

Age of initial sexual intercourse? : _____ Number of lifetime Partners?: _____
 Have you ever been treated for a sexually transmitted disease (STD)?: Y N
 Do you use condoms? Y N How often?: _____
 Is there or has there been violence in your sexual relationships? Y N
 Have you ever been sexually abused or raped? Y N

Health Habits:

Smoking: Y N How many? _____ How many years?: _____
 Drinking: Y N How much? _____ How often?: _____
 Drug use (including marijuana): Y N Type: _____ How often: _____
 Do you have concerns about your use of drugs or alcohol? Y N
 Exercise: More than 3x/week: _____ Weekly: _____ Rarely: _____
 Eating habits: Excellent: _____ Fair: _____ Unhealthy: _____
 Do you ever make yourself vomit after eating? Y N
 Do you ever restrict your eating? Y N
 Have you ever had a history of anorexia/bulimia? Y N

(DO NOT WRITE BELOW)

Provider's notes:

S/:

Patient's name: _____ Date: _____

CC: _____

HPI: _____

General ROS:

General: Changes in weight, fatigue, fever, chills, lymphadenopathy **Skin:** Rashes, itching, jaundice
HEENT: Headache, dizziness, visual disturbances **CARD/RESP:** chest pain, palpitations, SOB, cough
GI: Abd pain, nausea, vomiting, constipation, diarrhea **GU:** dysuria, frequency, urgency, flank pain
Vascular: Severe leg pain **Psych:** Nervousness, tension, mood changes, depression, increased stress
 Comments on ROS: _____

Gyn ROS

Vaginal Discharge: Y N Description: _____
 Pruritis: Y N Description: _____
 Genital lesions: Y N Description: _____
 Pelvic pain: Y N Description: _____
 Dyspareunia: Y N Description: _____
 Sexual partner with SX: Y N SX: _____ DX: _____ RX: _____
 Intermenstrual bleeding: Y N Post-coital bleeding: Y N
 Nipple discharge: Y N Recent changes in breasts: Y N
 BSE: Y N Frequency: _____ Douche: Y N Comments: _____

Assessment:

Wt: _____ lbs Ht: _____ BP: _____ T: _____ RR: _____ P: _____

Appearance: _____

Lymph: (-) enlargement _____ Not exam: _____ Other: _____

HEENT: WNL: _____ Not exam: _____ Other: _____

Lungs: CTA bilat: _____ Not exam: _____ Other: _____

Cardiac: S1S2, RRR: _____ (-) m/r/g: _____ Not exam: _____ Other: _____

Skin: WNL: _____ Not exam: _____ Other: _____

Thyroid: (-) nodules _____ (-) enlargement: _____ Not exam: _____ Other: _____

Abdomen: BS x 4: _____ Non-tender: _____ Tender: _____

No organomegaly: _____ No masses: _____ Other: _____

Breasts:

No masses: _____ No nipple discharge: _____ Not exam: _____

Other: _____

Vulva: NL: _____ Not exam: _____

Masses: _____

Lesions: _____

Other: _____

Cervix:

NL: _____ Not exam: _____ Discharge: _____

Other: _____

Os: Nullip: _____ Parous: _____ Closed: _____ Dilated: _____

Vagina: NL: _____ Not exam: _____ Discharge: _____ Lesions: _____

Uterus: NL: _____ Not exam: _____ Other: _____

Adnexa: NL: _____ Not exam: _____

Right: Not palpable: _____ Size: _____ Other: _____

Left: Not palpable: _____ Size: _____ Other: _____

Wet Mount: Y N KOH: _____ pH: _____

Diagnostic testing:

Urine dip: NA Vaginal cx (bacterial vaginosis, trichomonas/yeast): _____

PAP: _____ GC: _____ Chlamydia: _____

Labs: _____

Education: SBE: _____ Family Planning: _____ STD: _____ Safer Sex: _____

Sexual Hygiene: _____ Health Habits: _____ Specifics: _____

Assessment/Plan (including prescriptions/samples):

Referrals:

Follow-up: RTC: _____ for _____ or PRN.

Health Care Provider/ Date

