PATIENT INTAKE HISTORY

PATIENT NAME	BIRTH DATE: / /	INSURANCE:	DATE: / /
WHO REFERRED YOU TO OUR OFFICE:			

OBSTETRIC HISTORY

	NUMBER		NUMBER		NUMBER
PREGNANCIES		ABORTIONS		MISCARRIAGES	
PREMATURE BIRTHS (<37 WEEKS)		LIVE BIRTHS		LIVING CHILDREN	

NO.	BIRTH DATE	WEIGHT AT BIRTH	BABY'S SEX	WEEKS PREGNANT	TYPE OF DELIVERY (VAGINAL, CESAREAN, ETC.)	COMPLICATIONS?
1						
2						
3						
4						

GYNECOLOGIC HISTORY

LAST NORMAL MENSTRUAL PERIOD (FIRST DAY) / /	SEXUAL PARTNERS ARE ☐ MEN ☐ WOMEN ☐ BOTH
AGE PERIODS BEGAN:	PRESENT METHOD OF BIRTH CONTROL
LENGTH OF PERIODS (NUMBER OF DAYS OF BLEEDING):	WHEN WAS YOUR LAST PAP?
LENGTH OF CYCLE (1ST DAY MENSES TO 1ST DAY NEXT CYCLE)	HAVE YOU EVERY HAD AN ABNORMAL PAP?
ANY RECENT CHANGES IN PERIODS?	HAVE YOU EVERY HAD A SEXUALLY TRANSMITTED DISEASE OR (HERPES, GONORRHEA, CHLAMYDIA, GENITAL WARTS, HPV)?
ARE YOU CURRENTLY SEXUALLY ACTIVE?	
HAVE YOU EVER HAD SEX?	DO YOU DO REGULAR SELF BREAST EXAMS?
NUMBER OF SEXUAL PARTNERS (LIFETIME):	

SOCIAL HISTORY

	YES	NO	PHYSICIAN'S NOTES
EVERY SMOKED? CURRENT SMOKING: PACKS PER DAY: YEARS:	☐	☐	
ALCOHOL DRINKS PER DAY: DRINKS PER WEEK:	☐	☐	
RECREATIONAL DRUG USE	☐	☐	
SEAT BELT USE	☐	☐	
REGULAR EXERCISE:	☐	☐	
DAIRY PRODUCT INTAKE/CALCIUM SUPPLEMENTS:	☐	☐	
ARE YOU WORKING? WHAT TYPE OF WORK?	☐	☐	
HAVE YOU BEEN SEXUALLY ABUSED, THREATENED, OR HURT BY ANYONE?	☐	☐	

CURRENT MEDICATIONS: ☐NONE

(Including vitamins, herbs, nonprescription medications)
ALLERGIES ☐ **NONE**

IMMUNIZATIONS/TEST

	DATE
TETANUS-DIPHTHERIA BOOSTER	
HEPATITIS A VACCINE	
VARICELLA VACCINE	
MEASLES-MUMPS-RUBELLA (MMR) VACCINE	
INFLUENZA VACCINE (FLU SHOT)	
HEPATITIS B VACCINE	
PNEUMOCOCCAL VACCINE	