Open Door Gynecology Services

PATIENT INTAKE AND HISTORY

(Please answer to the best of your ability. Don't worry too much about answers you do not know)

Today's date: _____ **Legal Name:** _____

Preferred Name: _____ **Date of Birth:** _____

What brings you to the office today? _____

Most recent tests:

Last Mammogram: _____ Last Colonoscopy: _____ Last Dexa:_____

Other (please specify): _____

Medication: List any medications (and dosage), vitamins or herbs you are currently taking

☐ No Current meds

Drug Name	Dosage	Drug Name	Dosage

Menstrual & Gynecological History:

First day (date) of last period: _____ Post-menopausal Hysterectomy

Are your periods regular? Yes No

Do you have spotting between periods? Yes No

Age at first period:_____

How many days from the *first day* of your period to the *first day* of your next period?_____

How many days do your periods last?_____

Is your flow: light moderate heavy

Are your periods painful? Yes No

Do you have other symptoms with your periods? Yes No

If yes, please list: _____

When was your last pap smear? _____ Results were: normal abnormal

Have you ever had an abnormal pap smear? Yes No

If yes, when and what was the diagnosis?: _____

Did you have a procedure to treat the abnormal pap?: _____

Are you using birth control? Yes No

If yes, what form of contraception?: _____

Do you have pain with intercourse? Yes No

Do you leak urine? Yes No

Sexual History:

Are you currently sexually active? Yes No

With?: Men Women Both

Current number of partners? _____

Vaginal Oral Anal

Pregnancy History:

How many times have you been pregnant? _____ How many spontaneous miscarriages? ____

How many pre-term deliveries? _____ How many ectopic pregnancies? _____

How many full-term deliveries? _____ How many terminations? _____

How many still births? _____ How many live births? _____

Names of children: _____

Birth date	Weeks Pregnant	Sex	Weight at birth	Length of labor	Vaginal or Cesarean	Complications w/ pregnancy/delivery

Complications in pregnancy continued: _____

_____

_____

Personal and Familial Medical History:

Do not have family history/Adopted

Mother: living deceased-cause_____ Age: _____

Father: living deceased-cause_____ Age: _____

Number of: Brother(s): _____ Sister(s): _____

Medical Problems (Past/Current):

_____

_____

_____

_____

Family History of Medical Problems? Which Relative?:

_____

_____

_____

_____

Past Surgical History: List significant surgeries or injuries (and the year they occurred)

_____

_____

_____

_____

Social History:

Please describe your current tobacco use:

Never smoked Former smoker Current every day smoker Current some day smoker

(If current smoker, how many per day? _____ Trying to quit

Do you use marijuana? Yes No

If yes, in what form and how often? _____

Have you ever used illicit drugs? Yes No

If yes, please indicate what type of drug and how often: _____

Do you drink alcoholic beverages? Yes No

If yes, please indicate what type of beverage and how many per day or per week _____

_____

Highest Level of Education:

Did not finish High School High School/GED Some College

College Graduate Graduate Degree

Review of Systems: Please check the circle next to any of the following symptoms or problems if you have experienced then recently or have concerns about then.

Fever	Weight gain	Weight loss	Rash
Blurred vision	Headache	Bleeding gums	Difficulty breathing
Breast mass	Chest pain	Breast pain	Fainting
Elevated BP	Short of breath	Abdominal pain	Constipation
Nausea	Vomiting	Nipple discharge	Frequent diarrhea
Bloody stool	Painful Urination	Bladder problems	Pelvic pain
Bleeding	Discharge	Leg cramps	Dizziness
Depression	Urine loss	Blood in urine	Feces loss

Please fill out this last chart only if you are here for a PREGNANCY VISIT

Genetic Screen:

Please mark circle under 'Y' if anyone in your family or partner's/donor's family have had the following. Mark circle under 'N' if it is not applicable.

Screening	Y or N	Screening	Y or N
Will you be less than 35 yrs at the time of delivery?		Autism	
Neural Tube defect, Spina Bifida/Anencephaly		If yes to Autism, was person tested for Fragile X?	
Trisomy 21		Mental Disability	
Congenital Heart Defect		If yes to mental disability, was the person tested for Fragile X?	
Tay-Sachs Disease		Sickle Cell Disease or trait	
Canavan Syndrome		Recurrent pregnancy loss/stillbirth	
Hemophilia or Hematological Disease		Other Inherited Genetic/Chromosomal disorder	
Huntington's Disease		Other physical disability	
Huntington's Chorea		Other Birth Defect	