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? _____

Preferred Pharmacy: _____

Most recent tests:

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

Other (please specify): _____

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 pre-term deliveries? _____

How many full-term deliveries? _____

How many still births? _____

How many spontaneous miscarriages?

How many ectopic pregnancies? _____

How many terminations? _____

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