# Patient Intake Form – OB/GYN

Please complete this brief history to assist me in providing the best care possible.
This form will be added to your medical records.

Name_____ Preferred Name_____ Preferred Pronouns (i.e. she/he;her/him;they/them)_____

Birthdate_____ Who referred you? _____

Reason For Visit _____

## SEXUALITY / GENDER IDENTITY

What is your sexual orientation?
- ☐ Straight/Heterosexual
- ☐ Lesbian/Gay
- ☐ Bisexual
- ☐ Other_____
- ☐ Decline to state.

What sex were you assigned at birth?
- ☐ Female
- ☐ Male
- ☐ Decline to state.

What is your gender identity?
- ☐ Female
- ☐ Transgender woman
- ☐ Transgender man
- ☐ Gender queer
- ☐ Decline to state.

## RECENT EXAM

| *Type of Exam* | *Date of last exam* | *Location of exam* |
|---|---|---|
| Pap Test | | |
| Mammogram | | |
| Colonoscopy | | |
| Pelvic/Transvaginal Ultrasound | | |
| Bone density study | | |

## GYNECOLOGIC / OBSTETRIC HISTORY

Date of last menstrual period _____

Age (years) at 1st period _____; My period usually occurs every ___days and lasts for ___ days; Age at Menopause ___

Do you have history of (if yes, please provide date and describe)
- ☐ Abnormal Pap Test _____
- ☐ Ovarian Cyst _____
- ☐ Fibroids _____
- ☐ Sexually Transmitted Infection _____
- ☐ Abnormal Uterine Bleeding _____

Have you ever used oral contraceptives (if so for how many years)? _____

Have you ever used hormone replacement therapy (if so for how many years)? _____

Are you sexually active? ☐No ☐ Yes Any problems? _____

Total Number of Pregnancies _____

# Of Vaginal Delivers ___; Cesarean Sections ___; Miscarriages ___; Abortions ___; Ectopic Pregnancies ___

| Pregnacy # | Month | Year | #of weeks | Baby Weight | Sex | Delivery Type | Complications |
|---|---|---|---|---|---|---|---|
| 1 | | | | | | | |
| 2 | | | | | | | |
| 3 | | | | | | | |
| 4 | | | | | | | |
| 5 | | | | | | | |

Name _____ Birthdate _____

## CURRENT MEDICATION (Include vitamins, herbs and other supplements)

| Name of Medication | Dosage | How often |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**Are you allergic to any medications?** ☐ No ☐ Yes (Please specify medicaton/reaction) _____

**Latex Allergy**? ☐ No ☐ Yes **Tape Allergy**? ☐ No ☐ Yes **Iodine Allergy**? ☐ No ☐ Yes **Other Allergies** _____

## SURGICAL HISTORY

| Name of Procedure | Date of Procedure | Reason for Procedure |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

## FAMILY HISTORY

Do you have a family member with any of the following cancers (if yes please list which family member & age of diagnosis)

- ☐ Breast Cancer _____
- ☐ Ovarian Cancer _____
- ☐ Uterine/Endometrial Cancer _____
- ☐ Prostate Cancer _____
- ☐ Pancreatic Cancer _____
- ☐ Colon Cancer _____
- ☐ Melanoma _____
- ☐ Other Cancer (specify) _____

## SOCIAL HISTORY

Do you exercise? If so, what do you do? _____

Occupation _____ Marital Status _____

Do you smoke? ☐ No ☐ Yes How many packs/day _____; If you quit, when was this? _____

Do you drink alcohol? ☐ No ☐ Yes How many drinks/week _____; Recreational Drugs? (specify)_____

## MEDICAL HISTORY (either now or in the past/detail below with year of diagnosis/treatment)

- ☐ Asthma _____
- ☐ Cancer _____
- ☐ Cardiac disease _____
- ☐ High Blood Pressure _____
- ☐ Hyperlipidemia/ Cholesterol _____
- ☐ Irritable Bowel Syndrome _____

- ☐ Inflammatory Bowel Disease _____
- ☐ Lupus _____
- ☐ Osteoporosis/ Osteopenia _____
- ☐ Stoke _____
- ☐ Blood Clots _____
- ☐ Thyroid disease (low / high) _____
- ☐ Reflux (GERD) _____

Psychiatric Diagnosis

- ☐ Anxiety _____
- ☐ Depression _____
- ☐ High Blood Pressure _____
- ☐ Bipolar disorder _____
- ☐ Other _____