

# Patient History Intake (OBG)

Today's Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

How did you come to visit our office? Yellow Pages Ad (specify which phonebook): \_\_\_\_\_

Referred by a friend: \_\_\_\_\_ Referred by family member: \_\_\_\_\_

Sent by my physician, Dr. \_\_\_\_\_ Other (please specify): \_\_\_\_\_

Please describe the reason(s) for this visit: \_\_\_\_\_

Do you have any questions, problems, symptoms or concerns that you would like to discuss with us today? \_\_\_\_\_

LIST ANY MEDICATIONS you are taking, including non-prescription drugs, vitamins, herbals: \_\_\_\_\_

## Review of Systems:

Do you have now or have you had persistent symptoms within the past year?

<b>Const</b>	Weight Gain/Loss .....no yes	<b>CV</b>	Chest pain .....no yes	<b>Psych</b>	Depression .....no yes
	Fever .....no yes		Rapid heart beat.....no yes		Mood swings.....no yes
	Fatigue .....no yes		Swollen hands/feet ....no yes		Sleep Disturbances.....no yes
<b>Eyes</b>	Dry eyes .....no yes	<b>Skin</b>	Skin rash .....no yes	<b>Neuro</b>	Seizures .....no yes
	Vision changes.....no yes		Painful breasts.....no yes		Frequent headaches ...no yes
<b>ENT</b>	Mouth sores .....no yes		Breast lumps .....no yes		Dizziness .....no yes
	Sore throat .....no yes		Nipple discharge .....no yes		Numbness .....no yes
	Ringing in ears .....no yes	<b>GI</b>	Persistent diarrhea .....no yes	<b>MSK</b>	Joint or muscle pain .....no yes
	Sinus headaches .....no yes		Bloody stools.....no yes		Muscle weakness .....no yes
<b>Resp</b>	Persistent cough .....no yes		Nausea, vomiting .....no yes	<b>Lymph</b>	Swollen lymph nodes ...no yes
	Coughing blood.....no yes		Constipation .....no yes	<b>Heme</b>	Easy bleeding .....no yes
	Wheezing .....no yes		Bloating/gas.....no yes		Easy bruising .....no yes
	Shortness of breath.....no yes		Abdominal pain.....no yes	<b>Endo</b>	Night sweats .....no yes
<b>CV</b>	Shortness of breath with activity .....no yes	<b>ALL</b>	Hives, blisters.....no yes		Hot/cold intolerance ...no yes
			Red, itchy eyes .....no yes		_____
		<b>Renal</b>	Persistent sore throat..no yes	<b>Other</b>	_____
			Pain burning w/urination no yes	<b>Hot</b>	_____
			Do you have to strain/push when urinating no yes	<b>Flashes</b>	_____no yes
	Difficulty breathing while lying down .....no yes		Previous kidney/bladder infection no yes	<b>Pain w/ Inter course</b>	_____no yes

## Female Genitourinary (ROS):

### All patients:

Date of last pap smear? \_\_\_\_\_  
Any abnormal pap smears? .....no yes  
Date of last mammogram \_\_\_\_\_  
Number or pregnancies: \_\_\_\_\_

Age period began \_\_\_\_\_  
Date of last period: \_\_\_\_\_  
Frequency of periods: \_\_\_\_\_  
Average # of days: \_\_\_\_\_  
Method of contraception: \_\_\_\_\_

### Menopausal Patients only:

Do you use hormones? ...no yes  
If so, type: \_\_\_\_\_  
Any vaginal bleeding? ...no yes  
Date of last colonoscopy? \_\_\_\_\_  
When did you menstrual periods  
stop? \_\_\_\_\_

Number of live births: \_\_\_\_\_

Did you breast feed? .....no yes  
Monthly breast self-exams? .....no yes  
Any problem w/leaking urine? ...no yes  
Are you sexually active?.....no yes

Satisfied with this method? .....no yes  
Menstrual Flow Is usually: \_\_\_\_\_  
Are your periods usually painful no yes  
Do you clot with your periods no yes

Have you had a Bone Density test?  
.....no yes

## Drug allergies (ROS): \_\_\_\_\_

Have you EVER had a sexually transmitted Infection? no yes

If yes, name of Infection \_\_\_\_\_

**Past Medical History:**

Have you ever had the following?

Heart disease ..... no	yes	Cancer ..... no	yes	Stomach Ulcer ..... no	yes
Arthritis ..... no	yes	Glaucoma ..... no	yes	Kidney disease ..... no	yes
Rheumatic Fever ..... no	yes	Asthma ..... no	yes	Thyroid Disease ..... no	yes
Anemia ..... no	yes	AIDS or HIV+ ..... no	yes	Bleeding tendency ..... no	yes
Tuberculosis ..... no	yes	Stroke ..... no	yes	Mitral Valve Prolapse ..... no	yes
Diabetes ..... no	yes	Hepatitis ..... no	yes	High Blood Pressure ..... no	yes
Allergies ..... no	yes	Blood Clotting Disorder ..... no	yes		

**Past Surgical History:**

Have you ever had the following?

Hysterectomy .....no	yes	Breast biopsy .....no	yes	Colposcopy.....no	yes
Surgery on tubes/ovaries.....no	yes	Breast cyst aspiration .....no	yes	Urologic.....no	yes
Cesarean delivery .....no	yes	Mastectomy .....no	yes	Other: _____	

**Please list any other previous surgeries or any other major illnesses and dates:** \_\_\_\_\_

Previous Pregnancies:

Year of Birth	Length of Pregnancy In Months	Birth Wt.	Sex	# of hours In Labor	Delivery Type
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Miscarriages:

Year	How far along In months	Cause	Was a D&C performed	Complications
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**Family History:**

Has any blood relative ever had the following?

Breast Cancer .....no	yes	Stroke .....no	yes	Kidney disease ..... no	yes
Ovarian cancer .....no	yes	High blood pressure .no	yes	Tuberculosis .....no	yes
Colon cancer.....no	yes	Heart Disease .....no	yes	Depression ..... no	yes
Cervical cancer.....no	yes	Diabetes .....no	yes	Melanoma.....no	yes
Uterine caner..... no	yes			Thyroid Disease .....no	yes

**Social History:**

Marital Status: S M W D

Occupation: \_\_\_\_\_

Weight \_\_\_\_\_ Height \_\_\_\_\_

Do you exercise? No yes

Type: \_\_\_\_\_

How often? \_\_\_\_\_

Smoking (type & amount per day) \_\_\_\_\_

If former smoker, date quit: \_\_\_\_\_

Have you ever been sexually abused? No yes

Have you ever been physically or mentally abused? No yes

Do you get calcium in your diet? No yes

Supplements: \_\_\_\_\_

Alcohol (type and amount per week): \_\_\_\_\_

Do you use marijuana, cocaine or other drugs? No yes

**I VERIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.**

**X** \_\_\_\_\_  
Signature of patient or parent if minor

\_\_\_\_\_  
Date