ADULT-NON INFERTILITY/PATIENT INTAKE HISTORY

FOR OFFICE USE ONLY: □ ESTABLISHED PATIENT □ CONSULTATION □ LETTER SENT: / /

PATIENT NAME:		DATE: / /
MR#	SS#	BIRTH DATE: / /

ADDRESS:	
CITY:	STATE/ZIP:
HOME TELEPHONE: ( )	WORK TELEPHONE: ( )
EMPLOYER:	WORK HOURS:
INSURANCE:	POLICY NUMBER:
PRESCRIPTION COVERAGE WITH ABOVE POLICY? π YES π NO, NAME OF CARRIER:	
E-MAIL ADDRESS: (For confirming appointments only):	
PHARMACY NAME AND TELEPHONE:	
Race: □ AFRICAN AMERICAN □ ASIAN □ AMERICAN INDIAN □ CAUCASIAN □ HISPANIC □ UNKNOWN	
NAME OF SPOUSE/PARTNER:	DATE OF BIRTH:
EMERGENCY CONTACT:	RELATIONSHIP:
HOME TELEPHONE: ( )	WORK TELEPHONE: ( )
REFERRING PHYSICIAN/OB/GYN:	TELEPHONE: ( )
MAY WE DISCUSS YOUR TEST RESULTS WITH YOUR PARTNER/SPOUSE? □ YES □ NO	
IS IT OKAY TO LEAVE A MESSAGE ON YOUR VOICEMAIL? □ YES □ NO	
MAY WE CONTACT YOU AT WORK? □ YES □ NO	

If you are uncomfortable answering any questions, leave them blank; you can discuss them with your doctor or nurse.

GYNECOLOGIC HISTORY

	PHYSICIAN /NURSE NOTES
LAST NORMAL MENSTRUAL PERIOD (FIRST DAY)	
AGE PERIODS BEGAN:	
LENGTH OF PERIODS (NUMBER OF DAYS OF BLEEDING):	
ANY RECENT CHANGES IN PERIODS:	
PREVIOUS METHOD(S) OF BIRTH CONTROL:	
HOW OFTEN DO YOU GET PERIODS?	
WHEN WAS YOUR LAST PAP TEST?	
WAS IT NORMAL?	
HAVE YOU EVER HAD AN ABNORMAL PAP TEST?	
HAVE YOU EVER HAD A MAMMOGRAM?	

OBSTETRIC HISTORY - IF NO PREGNANCIES CHECK HERE □

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

#	BIRTH DATE	BIRTH WEIGHT	SEX	WEEKS PREGNANT	TYPE OF DELIVERY (VAGINAL, CESAREAN, ETC.)	COMPLICATIONS
1.						
2.						
3.						
4.						

PATIENT INTAKE HISTORY (Continued)

PATIENT NAME:	DATE: / /

CURRENT MEDICATIONS – IF NONE CHECK HERE ☐
(Including hormones, vitamins, herbs, nonprescription medications)

CURRENT MEDICATIONS	DOSAGE	WHO PRESCRIBED		CURRENT MEDICATIONS	DOSAGE	WHO PRESCRIBED

PERSONAL PAST HISTORY OF ILLNESSES

MAJOR ILLNESSES	YES (DATE)	NO	PHYSICIAN/NURSE NOTES
ASTHMA			
PNEUMONIA/LUNG DISEASE			
TUBERCULOSIS			
MITRAL VALVE PROLAPSE			
HEART ATTACK/PROBLEMS			
HIGH BLOOD PRESSURE			
STROKE			
BLOOD CLOTS IN LUNGS OR LEGS			
KIDNEY INFECTIONS/STONES			
SEXUALLY TRANSMITTED DISEASE			
HIV/AIDS			
THYROID DISEASE			
DIABETES			
EATING DISORDERS			
DEPRESSION/ANXIETY			
ARTHRITIS/JOINT PAIN/BACK PROBLEMS			
COLLAGEN VASCULAR DISEASE (LUPUS)			
CANCER			
REFLUX/HIATAL HERNIA/ULCERS			
HEPATITIS/JAUNDICE/LIVER DISEASE			
GALLBLADDER DISEASE			
COLITIS/CROHN'S DISEASE			
ANEMIA			
BLOOD TRANSFUSIONS			
MIGRAINE HEADACHES			
SEIZURES/CONVULSIONS/EPILEPSY			
OTHER			

PATIENT INTAKE HISTORY (Continued)

PATIENT NAME:	DATE: / /

PERSONAL PROFILE

SEXUAL ORIENTATION:	☐ HETEROSEXUAL ☐ HOMOSEXUAL ☐ BISEXUAL
MARITAL STATUS:	☐ MARRIED ☐ LIVING WITH PARTNER ☐ SINGLE ☐ WIDOWED ☐ DIVORCED ☐ SEPARATED
NUMBER OF PRIOR MARRIAGES FOR YOU:	FOR PARTNER:
NUMBER OF PEOPLE IN HOUSEHOLD:	
EDUCATION COMPLETED:	☐ HIGH SCHOOL ☐ SOME COLLEGE ☐ COLLEGE /BA DEGREE ☐ GRADUATE DEGREE ☐ OTHER
OCCUPATION/JOB:	

OPERATIONS/HOSPITALIZATIONS – IF NONE CHECK HERE - ☐

SURGERY/REASON	DATE OR YEAR	HOSPITAL

INJURIES/ILLNESSES – IF NONE CHECK HERE - ☐

REASON	DATE OR YEAR	HOSPITAL

REVIEW OF SYSTEMS

Please check (x) if any of the following symptoms apply to you now or since adulthood
If you are not sure, please put a (?) next to the symptom

	NO	NOW	PAST	PHYSICIAN/NURSE'S NOTES
CONSTITUTIONAL				
WEIGHT LOSS	☐	☐	☐	
WEIGHT GAIN	☐	☐	☐	
FEVER	☐	☐	☐	
EYES				
DOUBLE VISION	☐	☐	☐	
VISION CHANGES	☐	☐	☐	
GLASSES/CONTACTS	☐	☐	☐	
SPOTS BEFORE EYES	☐	☐	☐	
EAR, NOSE, AND THROAT				
EARACHES	☐	☐	☐	
RINGING IN EARS	☐	☐	☐	
HEARING PROBLEMS	☐	☐	☐	
FREQUENT SINUS PROBLEMS	☐	☐	☐	
MOUTH SORES	☐	☐	☐	

PATIENT INTAKE HISTORY (Continued)

PATIENT NAME: | DATE: / /

REVIEW OF SYSTEMS (Continue)
Please check (x) if any of the following symptoms apply to you now or since adulthood
If you are not sure, please put a (?) next to the symptom

	NO	NOW	PAST	PHYSICIAN/NURSE'S NOTES
CARDIOVASCULAR				
PAINFUL BREATHING	☐	☐	☐	
CHEST PAIN OR PRESSURE	☐	☐	☐	
DIFFICULTY BREATHING ON EXERTION	☐	☐	☐	
SWELLING OF LEGS	☐	☐	☐	
RAPID OR IRREGULAR HEARTBEAT	☐	☐	☐	
RESPIRATORY				
WHEEZING/ASTHMA	☐	☐	☐	
SPITTING UP BLOOD	☐	☐	☐	
SHORTNESS OF BREATH	☐	☐	☐	
CHRONIC COUGH	☐	☐	☐	
GASTROINTESTINAL				
FREQUENT DIARRHEA	☐	☐	☐	
BLOODY STOOL	☐	☐	☐	
NAUSEA/VOMITING/INDIGESTION	☐	☐	☐	
CONSTIPATION	☐	☐	☐	
INVOLUNTARY LOSS OF GAS OR STOOL	☐	☐	☐	
GENITOURINARY				
BLOOD IN URINE	☐	☐	☐	
PAIN WITH URINATION	☐	☐	☐	
STRONG URGENCY TO URINATE	☐	☐	☐	
FREQUENT URINATION	☐	☐	☐	
ABNORMAL BLEEDING	☐	☐	☐	
PAINFUL PERIODS	☐	☐	☐	
PAINFUL INTERCOURSE	☐	☐	☐	
FIBROIDS	☐	☐	☐	
INFERTILITY	☐	☐	☐	
DES EXPOSURE	☐	☐	☐	
ABNORMAL VAGINAL DISCHARGE	☐	☐	☐	
MUSCULOSKELETAL				
MUSCLE WEAKNESS	☐	☐	☐	
MUSCLE OR JOINT PAIN	☐	☐	☐	
SKIN				
RASH	☐	☐	☐	
SORES	☐	☐	☐	
EXCESS BODY OR FACIAL HAIR	☐	☐	☐	
MOLES	☐	☐	☐	
SEVERE ACNE	☐	☐	☐	

PATIENT INTAKE HISTORY (Continued)

PATIENT NAME:	DATE: / /

REVIEW OF SYSTEMS (Continue)

	NO	NOW	PAST	PHYSICIAN/NURSE'S NOTES
BREASTS				
NIPPLE DISCHARGE	☐	☐	☐	
LUMPS	☐	☐	☐	
NEUROLOGIC				
DIZZINESS	☐	☐	☐	
SEIZURES	☐	☐	☐	
NUMBNESS	☐	☐	☐	
TROUBLE WALKING	☐	☐	☐	
SEVERE MEMORY PROBLEMS	☐	☐	☐	
FREQUENT OR SEVERE HEADACHES	☐	☐	☐	
EMOTIONAL	☐	☐	☐	
DEPRESSION OR FREQUENT CRYING	☐	☐	☐	
SEVERE ANXIETY	☐	☐	☐	
WOULD YOU LIKE A REFERRAL TO A COUNSELOR?	☐	☐	☐	
ENDOCRINE				
HAIR LOSS	☐	☐	☐	
DIABETES	☐	☐	☐	
HEAT OR COLD INTOLERANCE	☐	☐	☐	
ABNORMAL THIRST	☐	☐	☐	
HOT FLASHES	☐	☐	☐	
HEMATOLOGIC/LYMPHATIC				
FREQUENT BRUISES	☐	☐	☐	
CUTS THAT DO NOT STOP BLEEDING	☐	☐	☐	
ENLARGED LYMPH NODES (GLANDS)	☐	☐	☐	
ALLERGIC/IMMUNOLOGIC	☐	☐	☐	
MEDICATION ALLERGIES	☐	☐	☐	
IF ANY, PLEASE LIST ALLERGY AND TYPE OR REACTION:	☐	☐	☐	
OTHER ALLERGIES:	☐	☐	☐	
LIST TYPE OR REACTION:				

SOCIAL HISTORY

	YES	NO	PHYSICIAN/NURSE NOTES
EVER SMOKED?			
CURRENT SMOKING: PACKS PER DAY: YEARS:			
ALCOHOL: DRINKS PER DAY: DRINKS PER WEEK:			
RECREATIONAL DRUG USE:			
REGULAR EXERCISE: HOW LONG AND HOW OFTEN?			
HAVE YOU BEEN SEXUALLY ABUSED, THREATENED, OR HURT BY ANYONE			
WEIGHT CHANGES IN THE PAST YEAR?			

PATIENT INTAKE HISTORY (Continued)

PATIENT NAME:	DATE: / /

FAMILY HISTORY

MOTHER: □ LIVING □ DECEASED – CAUSE: AGE:	FATHER: □ LIVING □ DECEASED – CAUSE: AGE:
SIBLINGS: NUMBER LIVING: NUMBER DECEASED: CAUSE(S)/AGES(S):	
CHILDREN: NUMBER LIVING: NUMBER DECEASED: CAUSE(S)/AGES(S):	

ILLNESS	YES	WHICH RELATIVE(S) AND AGE OF ONSET	PHYSICIAN/NURSE NOTES
DIABETES			
STROKE			
HEART DISEASE			
BLOOD CLOTS IN LUNGS OR LEGS			
HIGH BLOOD PRESSURE			
HIGH CHOLESTEROL			
OSTEOPOROSIS (WEAK BONES)			
RECURRENT MISCARRIAGE			
INFERTILITY			
BIRTH DEFECTS			
MENTAL RETARDATION			
DRINKING OR DRUG PROBLEMS			
BREAST CANCER			
COLON CANCER			
OVARIAN CANCER			
UTERINE CANCER			
MENTAL ILLNESS/DEPRESSION			
CYSTIC FIBROSIS			
OTHER			

DATE REVIEWED: / /	PHYSICIAN SIGNATURE:
DICTATION #:	PHYSICIAN INITIALS:
DICTATION #:	PHYSICIAN INITIALS: