PATIENT INTAKE HISTORY

PATIENT NAME:	TODAY'S DATE:
NAME FOR US TO USE:	BIRTHDATE:
HOME PHONE:	OTHER PHONE:
REFERRED BY: ☐ PHYSICIAN ☐ FRIEND ☐ RELATIVE ☐ YELLOW PAGES ☐ NEWSPAPER ADS	

PERSONAL PROFILE

MARITAL STATUS: ☐ MARRIED ☐ LIVING WITH PARTNER ☐ SINGLE ☐ WIDOWED ☐ DIVORCED
SEXUAL ORIENTATION: ☐ HETEROSEXUAL ☐ HOMOSEXUAL ☐ BISEXUAL
NUMBER OF PEOPLE IN HOUSEHOLD:
SCHOOL COMPLETED: ☐ HIGH SCHOOL ☐ SOME COLLEGE ☐ COLLEGE ☐ GRADUATE DEGREE ☐ OTHER
CURRENT OR MOST RECENT JOB:

SOCIAL HISTORY

	YES	NO	NOTES
EVER SMOKED? CURRENT SMOKING: PACKS PER DAY: YEARS:	☐	☐	
ALCOHOL: DRINKS PER DAY: DRINKS PER WEEK:	☐	☐	
RECREATIONAL DRUG USE	☐	☐	
SEAT BELT USE	☐	☐	
REGULAR EXERCISE: HOW LONG AND HOW OFTEN?	☐	☐	
DAIRY INTAKE / CALCIUM SUPPLEMENTS: QUANTITY?	☐	☐	
SEXUAL, PHYSICAL, VERBAL, EMOTIONAL ABUSE?	☐	☐	

GYNECOLOGIC HISTORY

LAST NORMAL MENSTRUAL PERIOD (FIRST DAY): / /	
AGE PERIODS BEGAN:	
LENGTH OF PERIODS (NUMBER OF DAYS OF BLEEDING):	
PERIOD INTERVAL (DAYS FROM START TO START):	
ANY RECENT CHANGES IN PERIODS?:	
ARE YOU SEXUALLY ACTIVE?:	
HAVE YOU EVER HAD SEX?:	
NUMBER OF SEXUAL PARTNERS (LIFETIME):	
SEXUAL PARTNERS ARE ☐ MEN ☐ WOMEN ☐ BOTH	
PRESENT METHOD OF BIRTH CONTROL:	
HAVE YOU EVER USED AN INTRAUTERINE DEVICE (IUD) OR BIRTH CONTROL PILLS?:	
IF YES, FOR HOW LONG?:	
WHEN WAS YOUR LAST PAP TEST?	
WHAT WAS THE RESULT?:	
HAVE YOU EVER HAD AN ABNORMAL PAP TEST?:	
DO YOU DO REGULAR BREAST SELF-EXAMINATIONS?	

PATIENT INTAKE HISTORY (CONTINUED)

OBSTETRIC HISTORY

			NUMBER		NUMBER	
PREGNANCIES				ABORTIONS		MISCARRIAGES
PREMATURE BIRTHS				LIVE BIRTHS		LIVING CHILDREN
NO.	BIRTH DATE	WEIGHT	GENDER	WEEKS PG	DELIVERY TYPE (Vag,Ces)	COMPLICATIONS
1						
2						
3						
4						
5						

PHYSICIAN'S NOTES ON OBSTETRIC HISTORY:

CURRENT MEDICATIONS

INCLUDING HORMONES, VITAMINS, HERBS, NONPRESCRIPTION MEDICATIONS

DRUG NAME	DOSAGE	WHO PRESCRIBED	DRUG NAME	DOSAGE	WHO PRESCRIBED

ALLERGIES

LIST ALLERGIES:

FAMILY HISTORY

MOTHER: ☐ LIVING ☐ DECEASED-CAUSE: AGE:

FATHER: ☐LIVING ☐ DECEASED-CAUSE: AGE:

SIBLINGS: NUMBER LIVING: NUMBER DECEASED: CAUSE(S)/AGE(S):

CHILDREN: NUMBER LIVING: NUMBER DECEASED: CAUSE(S)/AGE(S):

ILLNESS	YES	WHICH RELATIVE(S)	ILLNESS	YES	WHICH RELATIVE(S)
DIABETES	☐		TUBERCULOSIS	☐	
STROKE	☐		BIRTH DEFECTS	☐	
HEART DISEASE	☐		ALCOHOL / DRUG PROBLEM	☐	
CLOTS IN LUNGS OR LEGS	☐		BREAST CANCER	☐	
HIGH BLOOD PRESSURE	☐		COLON CANCER	☐	
HIGH CHOLESTEROL	☐		OVARIAN CANCER	☐	
OSTEOPOROSIS	☐		UTERINE CANCER	☐	

FAMILY HISTORY CONTINUED

HEPATITIS	☐		MENTAL ILLNESS	☐	
HIV / AIDS	☐		DEPRESSION	☐	

PERSONAL PAST HISTORY OF ILLNESSES

MAJOR ILLNESSES	YES (DATE)	MAJOR ILLNESSES	YES (DATE)
ASTHMA		REFLUX / HIATIAL HERNIA / ULCER	
PNEUMONIA / LUNG DISEASE		DEPRESSION / ANXIETY	
KIDNEY INFECTION / STONES		ANEMIA	
TUBERCULOSIS		BLOOD TRANSFUSIONS	
CHICKEN POX		SEXUALLY TRANSMITTED DISEASE	
HIV / AIDS		SEIZURE / CONVULSIONS / EPILEPSY	
HEART ATTACK / PROBLEMS		BOWEL PROBLEMS	
DIABETES		GLAUCOMA	
HIGH BLOOD PRESSURE		CATARACTS	
STROKE		ARTHRITIS / JOINT PAIN / BACK PROBLEMS	
RHEUMATIC FEVER		BROKEN BONES / OSTEOPOROSIS	
CLOTS IN LUNGS OR LEGS		HEPATITIS / JAUNDICE / LIVER DISEASE	
EATING DISORDERS		THYROID DISEASE	
CANCER		LUPUS / COLLAGEN VASCULAR DISEASE	
HEADACHES		GALL BLADDER DISEASE	
OTHER			

OPERATIONS / HOSPITALIZATIONS

REASON	DATE	HOSPITAL

INJURIES / ACCIDENTS / ILLNESSES

TYPE	DATE

IMMUNIZATIONS / TEST

	DATE		DATE
TETANUS-DIPHTHERIA BOOSTER		HEPATITIS A VACCINE	
INFLUENZA VACCINE (FLU SHOT)		HEPATITIS B VACCINE	
MEASLES-MUMPS-RUBELLA (MMR) VACCINE		VARICELLA VACCINE	
TUBERCULOSIS (TB) SKIN TEST		PNEUMOCOCCAL VACCINE	

REVIEW OF SYSTEMS

	NOW	PAST	PHYSICIAN'S NOTES
GLASSES / CONTACT			
HEARING PROBLEMS			
SINUS PROBLEMS			
MOUTH SORES			
CHEST PAIN / PRESSURE			
TROUBLE BREATHING WITH EXERTION			
SWELLING OF LEGS			
RAPID / IRREGULAR HEARTBEAT			
WHEEZING			
SHORTNESS OF BREATH			
CHRONIC COUGH			
FREQUENT DIARRHEA			
NAUSEA / VOMITING / INDIGESTION			
CONSTIPATION			
INVOLUNTARY LOSS OF GAS / STOOL			
BLOOD IN URINE			
STRONG URGENCY TO URINATE			
INCOMPLETE EMPTYING			
INVOLUNTARY URINE LOSS			
URINE LOSS WITH COUGH / LIFTING			
ABNORMAL BLEEDING			
PAINFUL PERIODS			
PREMENSTRUAL SYNDROME			
PAINFUL INTERCOURSE			
ABNORMAL VAGINAL DISCHARGE			
INFERTILITY			
MUSCLE OR JOINT PAIN			
DRY SKIN			
RASH			
PAIN IN BREAST			
NIPPLE DISCHARGE			
BREAST LUMPS			
SEIZURES			
FREQUENT / SEVERE HEADACHE			
DEPRESSION			
SEVERE ANXIETY			
HEAT / COLD INTOLERANCE			
HOT FLASHES / NIGHT SWEATS			
FREQUENT BRUISES			
ENLARGED LYMPH NODES			
FATIGUE			
MEDICATION ALLERGIES 1			
LIST DRUG & TYPE OF REACTION: 2			
3			
PATIENT'S SIGNATURE	DATE FIRST REVIEW		PHYSICIAN'S SIGNATURE

ANNUAL REVIEW OF HISTORY

DATE REVIEWED:	PHYSICIAN SIGNATURE
DATE REVIEWED:	PHYSICIAN SIGNATURE
DATE REVIEWED:	PHYSICIAN SIGNATURE
DATE REVIEWED:	PHYSICIAN SIGNATURE