Debbie A. Vigil MD., FACOG

GYNECOLOGIC INTAKE HISTORY

NAME: _____ **DOB:**_____ **DATE**_____

Review of systems: Please check any boxes that apply to you now or have applied in the past

		Past 3 months	4 months or more	Notes
1.	**Constitutional**			
	Weight loss			
	Weight gain			
	Fever			
	Fatigue			
2.	**Eyes**			
	Double vision			
	Spots before eyes			
	Vision changes			
3.	**Ears/Nose/Throat/ Mouth**			
	Ear aches			
	Ringing in ears			
	Sinus problems			
	Sore throat			
	Mouth sores			
	Dental problems			
4.	**Cardiovascular**			
	Painful breathing			
	Chest pain			
	Difficult breathing on exertion			
	Swelling of legs			
	Palpitations of heart			
5.	**Respiratory**			
	Wheezing			
	Spitting up blood			
	Shortness of breath			
	Chronic cough			
6.	**Gastrointestinal**			
	Frequent diarrhea			
	Blood in stool			
	Nausea/vomiting			
	Constipation			
7.	**Genitourinary**			
	Blood in urine			
	Pain with urination			
	Urgency			
	Frequency of urination			
	Incomplete emptying			
	Stress incontinence			
	Abnormal periods			
	Painful intercourse			
8.	**Musculoskeletal**			
	Joint pain			
	Muscle weakness			
9.	**Skin/Breast**			
	Pain in breast			
	Discharge			
	Masses			
	Rash			
	Ulcers			

TURN TO BACK SIDE

		Past 3 months	4 months or more	Notes
10	**Neurological**			
	Dizziness			
	Seizures			
	Numbness			
	Stroke			
	Trouble walking			
11	**Psychiatric**			
	Depression			
	Anxiety			
	Frequent crying			
12	**Endocrine**			
	Dry skin			
	Abnormal thirst			
	Hot flashes			
13	**Hematologic Lymphatic**			
	Frequent bruises			
	Cuts that do not stop bleeding			
	Enlarged lymph nodes			
14	**Allergic/Immunologic**			
	Seasonal allergies			
	Drug allergy			

Personal Past History Please check (X) any boxes that apply to you now or have applied in the past

MAJOR ILLNESSES	YES	NO	MAJOR ILLNESSES	YES	NO
Asthma /Chronic lung disease			Cancer		
Pneumonia			Ulcers		
Polycystic ovarian syndrome			Depression/anxiety		
Kidney infections/stones			Anemia		
Tuberculosis			Seizures/convulsions/epilepsy		
Venereal disease (sexually transmitted)			Bowel trouble		
Heart trouble/murmur			Glaucoma		
Diabetes			Arthritis		
High blood pressure			Fracture		
Stroke			Hepatitis/yellow jaundice		
Blood transfusion			Thyroid disease		
Deep vein thrombosis			Pulmonary embolism		
HIV			Liver disease		
Alzheimers/Dementia			Urinary incontinence		
Headaches/Migraine			Urinary infections		
Breast Disease			Arthritis		
Respiratory Disease			Immune suppression		
Gall Bladder Disease			Hiatal Hernia/PUD		

Operations/Hospitalizations (Describe Reason for Operation/Hospitalization) include dates

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

Injuries/Illnesses (Describe Type of Injury/Illness) include dates

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

Last Immunization or Test (include dates)

Tetanus — Pneumonia
Flu Shot — TB skin test
HPV vaccine Gardasil 1) 2) 3)

OB/GYN History

Total number of pregnancies _____ Number of Abortions _____ Number of Miscarriages _____ Number of Living Children _____
Adopted children _____

FAMILY HISTORY: Please check(X) Yes if a Family Member has or had one of these illnesses

Illness	Yes	No	Family Member	Illness	Yes	No	Family Member
Diabetes				Drinking problem			
Stroke				Breast cancer			
Heart disease				Colon cancer			
High blood pressure				Ovarian cancer			
Osteoporosis				Other Cancers who/what			_____

SOCIAL HISTORY: Personal Habits

	Yes	No		
Smoking			Caffeine:_____	Cups/day:_____
Alcohol			Packs per day: _____	Years:_____
Drug use			What drugs_____	How frequestly:_____
Seat belt use			Drinks per day: _____	Drinks per week:_____
Regular exercise				

Personal Profile

Marital Status: Long term partner Married Single Widowed Divorced

Number of Living Children_____ Number of people in household_____ Occupation_____

School completed High School College Graduate Degree Other

Personal Safety Yes No Currently

Has anyone close to you ever threatened to hurt you?

Has anyone ever hit, kicked, choked, or hurt you physically?

Has anyone, including your partner, ever forced you to have sex?

Are you ever afraid of your partner?

MEDICARE HIGH RISK CRITERIA: Please check (X) if you have ever been treated for any of the following infections:

Vaginosis Genital Warts Chlamydia
Trichomonas Gonorrhea Syphilis

	Yes	No	
Have you had a Pap smear in the last 7years?			
Have you ever had an abnormal Pap smear test?			if so when?_____
Did you begin sexual activity before you were 16 years old?			
Have you had more than 5 sexual partners in you lifetime?			
Did your mother take the drug DES when she was pregnant with you?			N/A

Completed by: Patient Office Nurse Physician Parent

Signature of patient: _____

_____

Date reviewed by physician with patient: _____ **Physician Signature_____**

Annual Review of History:

Date reviewed: _____ Physicians Signature:_____

Date reviewed: _____ Physicians Signature:_____

Date reviewed: _____ Physicians Signature:_____

Date reviewed: _____ Physicians Signature_____

Date reviewed: _____ Physicians Signature:_____

Date reviewed: _____ Physicians Signature:_____