# GYNECOLOGIC INTAKE HISTORY

Review of Systems:

| Constitutional | currently | past | N/A | Notes: |
|---|---|---|---|---|
| Weight loss | ❑ | ❑ | ❑ | |
| Weight gain | ❑ | ❑ | ❑ | |
| Fever | ❑ | ❑ | ❑ | |
| Fatigue | ❑ | ❑ | ❑ | |
| **Eyes** | | | | |
| Double vision | ❑ | ❑ | ❑ | |
| Spots before eyes | ❑ | ❑ | ❑ | |
| Vision Changes | ❑ | ❑ | ❑ | |
| **ENT/Mouth** | | | | |
| Ear aches | ❑ | ❑ | ❑ | |
| Ringing in ears | ❑ | ❑ | ❑ | |
| Sinus problems | ❑ | ❑ | ❑ | |
| Sore throat | ❑ | ❑ | ❑ | |
| Mouth sores | ❑ | ❑ | ❑ | |
| Dental problems | ❑ | ❑ | ❑ | |
| **Cardiovascular** | | | | |
| Painful breathing | ❑ | ❑ | ❑ | |
| Chest pain | ❑ | ❑ | ❑ | |
| Pain with exercise | ❑ | ❑ | ❑ | |
| Swelling of legs | ❑ | ❑ | ❑ | |
| Palpitations | ❑ | ❑ | ❑ | |
| **Respiratory** | | | | |
| Wheezing | ❑ | ❑ | ❑ | |
| Spitting up blood | ❑ | ❑ | ❑ | |
| Shortness of breath | ❑ | ❑ | ❑ | |
| Cough, chronic | ❑ | ❑ | ❑ | |
| **Gastrointestinal** | | | | |
| Diarrhea, frequent | ❑ | ❑ | ❑ | |
| Bloody stools | ❑ | ❑ | ❑ | |
| Nausea/vomiting | ❑ | ❑ | ❑ | |
| Constipation | ❑ | ❑ | ❑ | |
| **Genitourinary** | | | | |
| Blood in urine | ❑ | ❑ | ❑ | |
| Pain with urination | ❑ | ❑ | ❑ | |
| Urgency | ❑ | ❑ | ❑ | |
| Frequency of void | ❑ | ❑ | ❑ | |
| Incomplete emptying of bladder | ❑ | ❑ | ❑ | |
| Stress incontinence | ❑ | ❑ | ❑ | |
| Abnormal periods | ❑ | ❑ | ❑ | |
| Painful intercourse | ❑ | ❑ | ❑ | |
| **Musculoskeletal** | | | | |
| Muscle weakness | ❑ | ❑ | ❑ | |
| **Skin/Breast** | | | | |
| Pain in breast | ❑ | ❑ | ❑ | |
| Discharge | ❑ | ❑ | ❑ | |
| Masses | ❑ | ❑ | ❑ | |
| Rash | ❑ | ❑ | ❑ | |
| Ulcers | ❑ | ❑ | ❑ | |
| **Neurological** | | | | |
| Dizziness | ❑ | ❑ | ❑ | |
| Seizures | ❑ | ❑ | ❑ | |
| Numbness | ❑ | ❑ | ❑ | |
| Trouble walking | ❑ | ❑ | ❑ | |
| **Psychiatric** | | | | |
| Depression | ❑ | ❑ | ❑ | |
| Crying, frequent | ❑ | ❑ | ❑ | |

*PLEASE COMPLETE OTHER SIDE OF FORM*

| Please check (X) if any of the following apply to you now, in the past or often. | | | | |
|---|---|---|---|---|
| **Endocrine** | **currently** | **past** | **N/A** | **Notes:** |
| Dry skin | ❑ | ❑ | ❑ | |
| Abnormal Thirst | ❑ | ❑ | ❑ | |
| Hot Flashes | ❑ | ❑ | ❑ | |
| **Heme/Lymphatic** | | | | |
| Bruises, frequent | ❑ | ❑ | ❑ | |
| Cuts keep bleeding | ❑ | ❑ | ❑ | |
| Large lymph nodes | ❑ | ❑ | ❑ | |
| **Allergic/Immune** | | | | |
| Allergies | ❑ | ❑ | ❑ | |
| Drugs, other | ❑ | ❑ | ❑ | |

## PERSONAL PAST MEDICAL HISTORY:

| Major illnesses | Yes | No | Major illnesses | Yes | No |
|---|---|---|---|---|---|
| Asthma | | | Cancer | | |
| Pneumonia | | | Ulcers | | |
| Chronic Lung Disease | | | Depression/Anxiety | | |
| Kidney Infection/Stones | | | Anemia/Blood Transfusions | | |
| Tuberculosis | | | Seizures/Convulsions/Epilepsy | | |
| Venereal Disease | | | Bowel Trouble | | |
| Heart trouble/Murmur | | | Glaucoma | | |
| Diabetes | | | Arthritis/Joint Pain | | |
| High Blood Pressure | | | Fracture | | |
| Stroke | | | Hepatitis/Yellow Jaundice | | |
| Rheumatic Fever | | | Thyroid Disease | | |

## PAST SURGICAL PROCEDURES

| Type of surgery / Reason | Date | Type of surgery / Reason | Date |
|---|---|---|---|
| | | | |
| | | | |

## ILLNESSES/INJURIES

| Type | Date | Type | Date |
|---|---|---|---|
| | | | |
| | | | |

## OB/GYN HISTORY

| | | | | |
|---|---|---|---|---|
| Number of Pregnancies | | Number of Living children | | Prior GYN infections: |
| Deliveries | | Number of C-Sections | | |
| Abortions | | Number of Ectopic Preg | | Current contraception: |

## FAMILY HISTORY

| Illiness | Yes | Relative | Illness | Yes | Relative |
|---|---|---|---|---|---|
| Diabetes | | | Drinking Problem | | |
| Stroke | | | Breast Cancer | | |
| Heart Disease | | | Colon Cancer | | |
| High Blood Pressure | | | Ovarian Cancer | | |

## SOCIAL HISTORY / MEDICATIONS

| | | | | | | |
|---|---|---|---|---|---|---|
| Smoking | | Regular Exercise | | Widowed | | Medications: |
| Alcohol use | | Employed | | Separated | | |
| Drug use | | Married | | Single | | |
| Seat belt use | | Divorced | | | | |

**Completed by:** **Patient** ❑ **Nurse** ❑ **Physician** ❑ **Other:**_____

**Signature of Patient:** _____ **Signature of Physician:** _____

**Date of Birth:**_____

**Date:** _____