ALEXANDRIA WOMEN'S CENTER
Gynecologic Intake History

NAME:_____ BIRTH DATE:____/____/____ DATE:____/____/____

ADDRESS:_____

CITY: _____ STATE/ZIP: _____

HOME TEL: (___)_____ WORK TEL: (___)_____

EMPLOYER:_____ INSURANCE:_____

NAME OF SPOUSE/PARTNER:_____ REFERRED BY:_____

REVIEW OF SYSTEMS

PLEASE CHECK (X) IF ANY OF THE FOLLOWING APPLY TO YOU NOW, IN THE PAST OR OFTEN			
1. CONSTITUTIONAL	CURRENTLY	PAST	NOTES
Weight loss	☐	☐	
Weight gain	☐	☐	
Fever	☐	☐	
Fatigue	☐	☐	
2. EYES			
Double vision	☐	☐	
Spots before eyes	☐	☐	
Vision changes	☐	☐	
3. ENT/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	☐	☐	
Cough, chronic	☐	☐	
6. GASTROINTESTINAL			
Diarrhea, frequent	☐	☐	
Bloody 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			
Muscle weakness	☐	☐	

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PLEASE CHECK (X) IF ANY OF THE FOLLOWING APPLY TO YOU NOW, IN THE PAST OR OFTEN			
9. SKIN/BREAST	CURRENTLY	PAST	NOTES
Pain in breast	☐	☐	
Discharge	☐	☐	
Masses	☐	☐	
Rash	☐	☐	
Ulcers	☐	☐	
10. NEUROLOGICAL			
Dizziness	☐	☐	
Numbness	☐	☐	
Seizures	☐	☐	
Trouble Walking	☐	☐	
11. PSYCHIATRIC			
Depression	☐	☐	
Crying, frequent	☐	☐	
12. ENDOCRINE			
Dry skin	☐	☐	
Abnormal thirst	☐	☐	
Hot flashes	☐	☐	
13. HEMATOLOGICAL/LYMPHATIC			
Bruises, frequent	☐	☐	
Cuts do not stop bleeding	☐	☐	
Enlarged lymph node	☐	☐	
14. ALLERGIC/IMMUNOLOGIC			
Allergies	☐	☐	
Drugs, other	☐	☐	

PERSONAL PAST HISTORY

MAJOR ILLNESSES	YES	NO		YES	NO
Asthma	○	○	Cancer	○	○
Pneumonia	○	○	Ulcers	○	○
Chronic lung disease	○	○	Depression/anxiety	○	○
Kidney infections/stones	○	○	Anemia/Blood transfusions	○	○
Tuberculosis	○	○	Seizures/convulsions/epilepsy	○	○
Veneral disease	○	○	Bowel trouble	○	○
Heart trouble/murmur	○	○	Glaucoma	○	○
Diabetes	○	○	Arthirits/joint pain	○	○
High blood pressure	○	○	Fracture	○	○
Stroke	○	○	Hepatitis/Yellow jaundice	○	○

OPERATIONS/HOSPITALIZATIONS			
Reason	DATE	Reason	DATE
			DATE

INJURIES/ILLNESSES			
Type	DATE	Type	DATE

LAST IMMUNIZATION OR TEST			
	DATE		DATE
Tetanus		Pneumonia	
Flu shot		TB Skin Test	

OB/GYN HISTORY			
	NUMBER		NUMBER
Births		Abortions	
Miscarriages		Living children	

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CURRENT MEDICATION			
DRUG NAME	DOSAGE	DRUG NAME	DOSAGE

FAMILY HISTORY

ILLNESS	YES	RELATIVE	ILLNESS	YES	RELATIVE
	☐			☐	
	☐			☐	
	☐			☐	

SOCIAL HISTORY

HABITS				
Smoking	Yes ☐	No ☐	Packs per day_____	Years_____
Alcohol	Yes ☐	No ☐	Drinks per day_____	Drinks per week_____
Drug use	Yes ☐	No ☐		
Seat belt use	Yes ☐	No ☐		
Regular Exercise	Yes ☐	No ☐		

PERSONAL PROFILE

Marital Status Married ☐ Single ☐ Widowed ☐ Divorced ☐
Number of living children_____
Number of people in household_____
School completed Highschool ☐ College ☐ Graduate degree ☐ Other ☐
Current or most recent job_____

FAMILY HISTORY

- ☐ Has anyone close to you ever threatened to hurt you?
- ☐ Has anyone ever kicked, choked, or hurt you physically?
- ☐ Has anyone, including your partner, ever forced you to have sex?
- ☐ Are you ever afraid of your partner?

Completed by: Patient ☐ Office Nu ☐ rse Physician ☐

SIGNATURE OF PATIENT:_____

DATE REVIEWED BY PHYSICIAN WITH PATIENT:_____

PHYSICIAN SIGNATURE:_____

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