

SUBURBAN WOMEN'S HEALTHCARE NEW PATIENT INTAKE FORM

Patient Name: _____ DATE OF BIRTH: _____

Preferred Name: _____ Pronouns: _____

Reason for appointment: _____

GYN HISTORY:

Age of first menstrual period: _____

How often are your periods: _____

How many days do your periods last: _____

Last menstrual period: _____

Last PAP smear: _____

Have you ever had an abnormal pap smear:

no yes date: _____

Have you ever had surgery on your cervix/LEEP Procedure

no yes date: _____

Have you received the vaccine to prevent HPV ? no yes

Are you currently sexually active? no yes never

Are you currently using birth control? no yes, current birth control is _____

Sexual Preference

heterosexual homosexual other: _____

Personal History of:

Endometriosis PCOS Irregular Menstrual Cycle Painful Periods

Have you ever been treated for:

genital warts herpes

OBSTETRIC HISTORY:

Number of pregnancies _____ : vaginal delivery # _____ C-section # _____

Have you ever had:

ectopic pregnancy, if so how many _____

miscarriage, if so how many _____

abortion, if so how many _____

Any complications during your pregnancies?

PRESCRIBED MEDICATIONS: name of medication and current dose

MEDICATION ALLERGIES: name of medication and type of reaction

MEDICAL HISTORY: do you now have, or ever been diagnosed with the following?

- | | | |
|--|---|--|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Migraines | <input type="checkbox"/> Celiac disease |
| <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Migraine w Aura | <input type="checkbox"/> Osteopenia/Osteoporosis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Autoimmune disease | _____ |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Deep vein thrombosis | _____ |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Ulcerative colitis/Crohn's | _____ |
| <input type="checkbox"/> Asthma | | |

SURGICAL HISTORY:

- | | | |
|---|---|---|
| <input type="checkbox"/> tonsils | <input type="checkbox"/> C section | <input type="checkbox"/> Endometrial Ablation |
| <input type="checkbox"/> Appendix | <input type="checkbox"/> Tubal ligation | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Gall bladder | <input type="checkbox"/> Hysterectomy | |
| <input type="checkbox"/> D&C/hysteroscopy | <input type="checkbox"/> Oophorectomy | |
| <input type="checkbox"/> LEEP | <input type="checkbox"/> Laparoscopy | |

HEALTH SCREENING: have you ever had the following ?

- Mammogram: no yes date: _____
Colonoscopy: no yes date: _____
Bone Density: no yes date: _____
Pelvic Ultrasound: no yes date: _____

FAMILY HISTORY: please list anyone in your immediate family that has been diagnosed with the following? Include age of diagnosis, if able.

- | | |
|--|---|
| <input type="checkbox"/> Breast Cancer: | <input type="checkbox"/> Colon Cancer: |
| <input type="checkbox"/> Ovarian Cancer: | <input type="checkbox"/> High Blood Pressure: |
| <input type="checkbox"/> Uterine Cancer: | <input type="checkbox"/> Diabetes |

SOCIAL HISTORY:

What is your occupation? _____

Are you currently or have you ever been a smoker?

- never smoker yes, current #____ per day yes, former - quit date _____

Do you vape? no yes

Do you use marijuana? no yes

Any other drug use? no yes _____

Alcohol Consumption:

- never occasionally weekly daily (#____ per day)