Suburban Women's Healthcare, P.C.

Intake History Form

Name ____ DOB ______/_______/_______

Allergies: ____

____

Medications: ____ ____

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Menstrual Cycles started age _______ and stopped at age ________ Last Pap ________ Last Mammogram ________

Pregnancies ______ Deliveries ______ Children Alive _____ Miscarriages ______ Elective Interruptions __________

Medical Conditions

☐ Hypertension ☐ Hypothyroidism ☐ Elevated cholesterol ☐ Depression/Anxiety ☐ Asthma ☐ Diabetes

☐ Bone loss (osteopenia or osteoporosis) ☐ Arthritis

☐ Other ____

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Surgery

☐ Tonsils ☐ Appendix ☐ Gallbladder ☐ D&C ☐ LEEP ☐ Cesarean Section ☐ Tubal Ligation ☐ Hysterectomy

☐ Other ____

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Family History - List anyone in your immediate family with the following conditions:

☐ Breast Cancer _____________________________ ☐ Colon Cancer _________________________________

☐ Ovarian Cancer ____________________________ ☐ Uterine Cancer _______________________________

☐ Diabetes _________________________________ ☐ Hypertension ________________________________

☐ Other ____

Tobacco Use: ☐ Never ☐ Previous/Quit _______ ☐ Current ______ppd / _______ cig/day

Alcohol Use: ☐ Never/Occassional ☐ Weekly ☐ Daily # ________per day **Drug Use:** ☐ Yes ☐ No

☐ History of Abnormal Pap ☐ History of HPV ☐ History of Herpes ☐ History of Chlamydia/Gonorrhea