

**Georgia Center for Female Health**  
Gynecology Intake History

Name: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

City: \_\_\_\_\_

Home TEL: ( ) \_\_\_\_\_

State/Zip: \_\_\_\_\_

Work TEL ( ) \_\_\_\_\_

Employer: \_\_\_\_\_

Insurance: \_\_\_\_\_

Name of Spouse/Partner \_\_\_\_\_

Referred by: \_\_\_\_\_

**Review of systems: Please check ( ) Any boxes that apply to you now or have applied in the past**

<b>1. Constitutional</b>	<b>Currently</b>	<b>Past</b>	<b>Notes</b>
Weight Loss	[]	[]	
Weight Gain	[]	[]	
Fever	[]	[]	
Fatigue	[]	[]	
<b>2. Eyes</b>			
Double Vision	[]	[]	
Spots before eyes	[]	[]	
Vision Changes	[]	[]	
<b>3. Ear/Nose/Throat/Mouth</b>			
Ear aches	[]	[]	
Ringing in ears	[]	[]	
Sinus Problems	[]	[]	
Sore Throat	[]	[]	
Mouth Sores	[]	[]	
<b>4. Cardiovascular</b>			
Painful breathing	[]	[]	
Chest pain	[]	[]	
Difficult breathing on exertion	[]	[]	
Swelling of legs	[]	[]	
Palpitations of heart	[]	[]	
<b>5. Respiratory</b>			
Wheezing	[]	[]	
Spitting up blood	[]	[]	
Shortness of Breath	[]	[]	
Chronic cough	[]	[]	
<b>6. Gastrointestinal</b>			
Frequent diarrhea	[]	[]	
Blood Stool	[]	[]	
Nausea/vomiting	[]	[]	
Constipation	[]	[]	
<b>7. Genitourinary</b>			
Blood in urine	[]	[]	
Pain with urination	[]	[]	
Urgency	[]	[]	
Frequency in urination	[]	[]	
Incomplete emptying	[]	[]	
Stress incontinence	[]	[]	
Abnormal periods	[]	[]	
Painful intercourse	[]	[]	
<b>8. Musculoskeletal</b>			
Muscle Weakness	[]	[]	
<b>9. Skin/Breast</b>			
Pain in breast	[]	[]	
Discharge	[]	[]	
Masses	[]	[]	
Rash	[]	[]	
Ulcers	[]	[]	

Review of systems (continued) Please check  any boxes that apply to you now or have applied in the past.

	Currently	Past	Notes
<b>10. Neurological</b>			
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	
Numbness	<input type="checkbox"/>	<input type="checkbox"/>	
Trouble walking	<input type="checkbox"/>	<input type="checkbox"/>	
<b>11. Psychiatric</b>			
Depression	<input type="checkbox"/>	<input type="checkbox"/>	
Frequent crying	<input type="checkbox"/>	<input type="checkbox"/>	
<b>12. Endocrine</b>			
Dry skin	<input type="checkbox"/>	<input type="checkbox"/>	
Abnormal thirst	<input type="checkbox"/>	<input type="checkbox"/>	
Hot flashes	<input type="checkbox"/>	<input type="checkbox"/>	
<b>13. Hematologic/Lymphatic</b>			
Frequent bruises	<input type="checkbox"/>	<input type="checkbox"/>	
Cuts that do not stop bleeding	<input type="checkbox"/>	<input type="checkbox"/>	
Enlarged lymph nodes	<input type="checkbox"/>	<input type="checkbox"/>	
<b>14. Allergic / Immunologic</b>			
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	
Drug allergy	<input type="checkbox"/>	<input type="checkbox"/>	

Personal Past History Please Check  any boxes that apply to your now or have applied in the past.

<b>MAJOR ILLNESSES</b>					
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	Depression / Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Kidney infections / stones	<input type="checkbox"/>	<input type="checkbox"/>	Anemia / blood transfusions	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Seizures/convulsions/epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/>	Bowel trouble	<input type="checkbox"/>	<input type="checkbox"/>
Heart trouble / murmur	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis / joint pain	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Fracture	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis/ yellow jaundice	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>

**Operations/Hospitalizations** (Describe Reason for Operation/Hospitalization)

	Date		Date

**Injuries/Illnesses** (Describe type of Injury/illness)

	Date		Date

**Last Immunization or Test**

	Date		Date
Tetanus		Pneumonia	
Flu shot		TB skin test	

**OB/GYN History**

	Number		Number
Births		Abortions	
Miscarriages		Living children	

**Current Medications (List Drug Name(s) and dosage(s))**

--	--	--	--

<b>Family History:</b> Please check <input type="checkbox"/> <b>yes</b> if a <b>Family Member</b> has or had one of these illness.							
	Yes	No	Family Member		Yes	No	Family member
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>		Drinking problem	<input type="checkbox"/>	<input type="checkbox"/>	
Stroke	<input type="checkbox"/>	<input type="checkbox"/>		Breast cancer	<input type="checkbox"/>	<input type="checkbox"/>	
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>		Colon cancer	<input type="checkbox"/>	<input type="checkbox"/>	
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>		Ovarian cancer	<input type="checkbox"/>	<input type="checkbox"/>	

<b>Social History: Personal Habits</b>					
	<b>YES</b>	<b>NO</b>			
Smoking	<input type="checkbox"/>	<input type="checkbox"/>	<b>Packs per day:</b> _____	<b>Years:</b> _____	
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<b>Drinks per day:</b> _____	<b>Drinks per week:</b> _____	
Drug use	<input type="checkbox"/>	<input type="checkbox"/>			
Seat Belt Use	<input type="checkbox"/>	<input type="checkbox"/>			
Regular Exercise	<input type="checkbox"/>	<input type="checkbox"/>			

<b>Personal Profile</b>								
Marital Status:	<b>Married</b>	<input type="checkbox"/>	<b>Single</b>	<input type="checkbox"/>	<b>Widowed</b>	<input type="checkbox"/>	<b>Divorced</b>	<input type="checkbox"/>
Number of children living:	_____							
Number of people in household:	_____							
School Completed:	High School	<input type="checkbox"/>	College	<input type="checkbox"/>	Graduate Degree	<input type="checkbox"/>	Other	<input type="checkbox"/>
Current or most recent job::	_____							
<b>Personal Safety</b>	<b>Yes</b>	<b>No</b>						
Has anyone close to you ever threatened to hurt you ?	<input type="checkbox"/>	<input type="checkbox"/>						
Has anyone ever hit, kicked, choked, or hurt you physically??	<input type="checkbox"/>	<input type="checkbox"/>						
Has anyone, including your partner, ever forced you to have sex?	<input type="checkbox"/>	<input type="checkbox"/>						
Are you afraid of your partner??	<input type="checkbox"/>	<input type="checkbox"/>						

<b>Medicare "High Risk" Criteria:</b> Please check <input type="checkbox"/> if your have ever been treated for any of the following infections:					
<b>Vaginosis</b>	<input type="checkbox"/>	<b>Genital Warts</b>	<input type="checkbox"/>	<b>Chlamydia</b>	<input type="checkbox"/>
<b>Trichomonas</b>	<input type="checkbox"/>	<b>Gonorrhea</b>	<input type="checkbox"/>	<b>Syphillis</b>	<input type="checkbox"/>
				Yes	No
Have you had a Pap smear in the last 7 years?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had an abnormal Pap smear test?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did you begin sexual activity before you were 16 years old?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had more than 5 sexual partners in your lifetime?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever tested positive for the HIV virus?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did your mother take the drug DES when she was pregnant with you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Completed by:** Patient  Office Nurse  Physician

**Signature of Patient;** \_\_\_\_\_

**Date reviewed by physician with patient:** \_\_\_\_\_

**Physician Signature:** \_\_\_\_\_

**Annual Review of History:**

**Date reviewed:** \_\_\_\_\_ **Physician Signature:** \_\_\_\_\_

**Date reviewed:** \_\_\_\_\_ **Physician Signature:** \_\_\_\_\_

**Date reviewed:** \_\_\_\_\_ **Physician Signature:** \_\_\_\_\_