Sharon OB/GYN

Patient History Intake

Date Reviewed: _____

Patient Name: _____ Birth Date: _____ Age: _____ Date: _____

IMPORTANT: In order to provide the highest quality of health care possible, it is important that we have the following information. Please answer all of the doctorís questions as accurately as possible. If you do not understand the question please ask for assistance. Thank You.

Primary Care Dr.: _____ **Referred by:** _____

Please describe the reason(s) for this visit: _____

Do You have any problems you wish to discuss with us today? _____

Review Of Systems:

Do you have now or have you had within the past year: (Please check Y if yes or N if no)

		Y	N
Const:	Weight gain/loss	☐	☐
	Fever	☐	☐
	Fatigue	☐	☐
Eyes:	Dry eyes	☐	☐
	Vision changes	☐	☐
ENT:	Mouth sores	☐	☐
	Sore throat	☐	☐
	Ringing in ears	☐	☐
	Sinus headaches	☐	☐
Resp:	Persistent cough	☐	☐
	Coughing blood	☐	☐
	Wheezing	☐	☐
	Shortness of breath	☐	☐
CV:	Shortness of breath with activity	☐	☐
	Difficulty breathing lying down	☐	☐

		Y	N
CV:	Chest pain	☐	☐
	Rapid heart beat	☐	☐
	Swollen hands/ feet	☐	☐
Skin:	Skin rash	☐	☐
	Painful breasts	☐	☐
	Breast lumps	☐	☐
	Nipple discharge	☐	☐
GI:	Persistent diarrhea	☐	☐
	Bloody stools	☐	☐
	Nausea, vomiting	☐	☐
	Constipation	☐	☐
	Bloating/gas	☐	☐
	Abdominal pain	☐	☐
ALL:	Hives/blisters	☐	☐
	Red itchy eyes	☐	☐
	Persistent sore throat	☐	☐

		Y	N
Psych:	Depression	☐	☐
	Mood swings	☐	☐
	Sleep disturbances	☐	☐
Neuro:	Seizures	☐	☐
	Frequent headaches	☐	☐
	Dizziness	☐	☐
	Numbness	☐	☐
MSK:	Joint or muscle pain	☐	☐
	Muscle weakness	☐	☐
Lymph:	Swollen lymph nodes	☐	☐
Heme:	Easy bleeding	☐	☐
	Easy bruising	☐	☐
Endo:	Night Sweats	☐	☐
	Hot/cold intolerances		
Other:	_____		
	_____		
	_____		

Female Genitourinary (ROS):

All patients:

Date last pap: _____
Any abnormal paps: _____
Date last mammogram: _____
Number of pregnancies: _____
Number of live births: _____
Did you breast feed: _____
Monthly self breast-exams: _____
Any problems w/leaking urine: _____
Are you sexually active: _____
Any Problems? _____ Y _____ N

Pre-Menopausal patients only:

Age period began: _____
Date of last period: _____
Frequency of periods: _____
Average # of days: _____
Method of contraception: _____
Satisfied with this method: _____
Periods: ___ Heavy ____ NL ____ Light
Infertility: _____
Sexually transmitted Diseases: _____
_____

Menopausal patients only:

Do you use hormones: _____
If so, type: _____
Any vaginal bleeding: _____
Date of last colonoscopy: _____
Date of last bone density: _____
Cholesterol Level: _____

Drug Allergies: _____ _____ _____

List any medications and dosages: _____ _____ _____

_____ _____ _____ _____

OVER

Past Medical History

Have you had any of the following:

	Y	N		Y	N		Y	N	
Heart disease	☐	☐	Cancer	☐	☐	Kidney disease	☐	☐	Other:
Arthritis	☐	☐	Glaucoma	☐	☐	Thyroid disease	☐	☐	_____
Rheumatic fever	☐	☐	Asthma	☐	☐	Bleeding tendency	☐	☐	_____
Anemia	☐	☐	AIDS or HIV	☐	☐	Mitral valve prolapse	☐	☐	_____
Tuberculosis	☐	☐	Stroke	☐	☐	High blood pressure	☐	☐	_____
Diabetes	☐	☐	Hepatitis	☐	☐	Depression	☐	☐	
Allergies	☐	☐	Stomach ulcer	☐	☐	Psychiatric problems	☐	☐	

Past Surgical History

Have you had any of the following:

	Y	N		Y	N		Y	N	
Hysterectomy	☐	☐	Breast biopsy	☐	☐	Colposcopy	☐	☐	
Surgery on tubes/ovaries	☐	☐	Breast cyst aspiration	☐	☐	Urologic	☐	☐	
Cesarean delivery	☐	☐	Mastectomy	☐	☐	Other/date	_____		

Please list any other previous surgeries: _____

Family History:

Has any blood relative ever had the following:

	Y	N		Y	N		Y	N
1. Breast cancer	☐	☐	6. Stroke	☐	☐	10. Kidney Disease	☐	☐
2. Ovarian cancer	☐	☐	7. High blood pressure	☐	☐	11. Depression	☐	☐
3. Colon cancer	☐	☐	8. Heart disease	☐	☐	12. Bleeding disorders	☐	☐
4. Melanoma	☐	☐	9. Diabetes	☐	☐	13. Thromboembolic Disease	☐	☐
5. Osteoporosis	☐	☐						

If yes, who: _____

Social History:

Occupation: _____

Marital Status: _____S _____ M _____W _____D

Do you exercise?: _____

Type: _____ How often: _____

Smoking (type & amount per day): _____

If former smoker, date quite: _____

Have you every been sexually abused?: _____

Have you have been physically or mentally abused?: _____

Do you get calcium in your diet?: _____

Supplements: _____

Alcohol (type and amount per week): _____

Do you use marijuana, cocaine or other drugs: _____

Weight: _____ Height: _____

I VERIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

_____ _____

Signature of patient or parent if minor Date