



MEDICAL CLINIC P. A.

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Patient Information Sticker

GYNECOLOGIC INTAKE HISTORY

Form completed by: ___ Self ___ Physician ___ Other ___ Date: ___/___/___

Past or Current Medical Problems

Form with three horizontal lines for medical problems

Surgeries/Hospitalizations

Form with three horizontal lines for surgeries/hospitalizations

OB/GYN History

OB/GYN History form containing pregnancy, delivery, and surgical history questions

Medications

Form with three horizontal lines for medications

Allergies

Allergies form with 'No Known Allergies' and three horizontal lines

Social History

Social History form containing smoking, alcohol, drugs, marital status, and abuse history questions

Immunizations

Immunizations form with lines for Tetanus, Influenza, Pneumonia, and Hepatitis B

Family History

Mom:	_____ alive - current age: _____	_____ deceased - age of death: _____	cause: _____
Dad:	_____ alive - current age: _____	_____ deceased - age of death: _____	cause: _____
Illnesses:			
High Blood Pressure	_____ No	_____ Yes	_____
Diabetes	_____ No	_____ Yes	_____
Heart Disease	_____ No	_____ Yes	_____
Osteoporosis	_____ No	_____ Yes	_____
Cancer	_____ No	_____ Yes	_____
Stroke	_____ No	_____ Yes	_____

Review of Systems

1.) Constitutional:			
weight changes	_____ No	_____ Yes	_____
fatigue	_____ No	_____ Yes	_____
2.) Skin/Breast:			
pain or mass in breast	_____ No	_____ Yes	_____
nipple discharge	_____ No	_____ Yes	_____
skin lesion	_____ No	_____ Yes	_____
3.) Eyes:			
vision problems	_____ No	_____ Yes	_____
4.) ENT/Mouth:			
hearing problems	_____ No	_____ Yes	_____
sinus problems	_____ No	_____ Yes	_____
dental problems	_____ No	_____ Yes	_____
5.) Cardiovascular:			
chest pain/shortness of breath	_____ No	_____ Yes	_____
swelling in legs	_____ No	_____ Yes	_____
palpitations of heart	_____ No	_____ Yes	_____
6.) Respiratory:			
wheezing or cough	_____ No	_____ Yes	_____
7.) Gastrointestinal:			
nausea or vomiting	_____ No	_____ Yes	_____
diarrhea or constipation	_____ No	_____ Yes	_____
blood in stool	_____ No	_____ Yes	_____
8.) Urinary:			
pain with urination	_____ No	_____ Yes	_____
blood in urine	_____ No	_____ Yes	_____
incontinence	_____ No	_____ Yes	_____
9.) Hematological:			
frequent bruising	_____ No	_____ Yes	_____
cuts do not stop bleeding	_____ No	_____ Yes	_____
enlarged lymph nodes	_____ No	_____ Yes	_____
10.) Psychiatric:			
depression	_____ No	_____ Yes	_____
anxiety	_____ No	_____ Yes	_____

Signature of Patient: _____

Date: ____/____/____

Health Care Maintenance

Mammogram:	_____
Colonoscopy:	_____
Dexascan:	_____
Lipid Profile (Cholesterol):	_____
Pap Smear:	_____

Reviewed by Physician:

Date: ____/____/____

Physician Signature: _____

