FOR OFFICE USE ONLY

- ☐ NEW PATIENT
- ☐ ESTABLISHED PATIENT
- ☐ CONSULTATION

PATIENT INTAKE HISTORY

PATIENT NAME:	BIRTH DATE: / /	DATE: / /
ADDRESS:		
CITY:	STATE/ZIP:	
HOME TELEPHONE: ( )	WORK TELEPHONE: ( )	
EMPLOYER:	INSURANCE CO:	POLICY NO:
NAME YOU WOULD LIKE TO USE:	PRIMARY LANGUAGE:	
NAME OF SPOUSE/PARTNER:	EMERGENCY CONTACT:	
NAME OF SPOUSE/PARTNER:	RELATIONSHIP:	
	HOME TELEPHONE: ( )	
	WORK TELEPHONE: ( )	
REFERED BY:		
WHY HAVE YOU COME TO THE OFFICE TODAY?		
IS THIS IS A NEW PROBLEM?		
PLEASE DESCRIBE YOUR PROBLEM, INCLUDING WHERE IT IS, HOW SEVERE IT IS, AND HOW LONG IT HAS LASTED:		

If you are uncomfortable answering any questions, leave them blank; you can discuss them with your doctor or nurse.

GYNECOLOGICAL HISTORY

	PHYSICIAN'S NOTES
LAST NORMAL MENSTRUAL PERIOD (FIRST DAY):	
AGE PERIODS BEGAN:	
LENGTH OF PERIODS (NUMBER OF DAYS OF BLEEDING):	
NUMBER OF DAYS BETWEEN PERIODS:	
ANY RECENT CHANGES IN PERIODS?	
ARE YOU CURRENTLY SEXUALLY ACTIVE?	
HAVE YOU EVER HAD A STD?	
NUMBER OF SEXUAL PARTNERS (LIFETIME):	
PRESENT METHOD OF BIRTH CONTROL:	
HAVE YOU EVER USED AN IUD OR BIRTH CONTROL PILLS?	
IF YES, FOR HOW LONG?	
WHEN WAS YOUR LAST PAP TEST?	
WHAT WAS THE RESULT?	
HAVE YOU EVER HAD AN ABNORMAL PAP TEST?	
DO YOU DO BREAST SELF-EXAMINATIONS?	
HAVE YOU BEEN EXPOSED TO DIETHYLSTILBESTROL (DES)?	