

Your answers to the following questions will help us to understand your medical history and the concerns you'd like to discuss with your doctor. Please fill out as much of the form as possible. If you cannot answer some of the questions or feel uncomfortable answering them, leave them blank. Thank you for your help.

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

Today's Date: \_\_\_\_\_

Birthdate: \_\_\_\_\_

PCP: \_\_\_\_\_

Name of any other providers we should send our note to: \_\_\_\_\_

What gynecologic issues would you like to discuss today?  
\_\_\_\_\_

### Menstrual and Sexual History

How old were you when you had your first period? \_\_\_\_\_

Are you having periods? If no, skip this section:

**Having Periods:** What date was the first day of your most recent (*last*) period? \_\_\_\_\_

Are your periods regular?  Yes  No

How many days are there between your periods? (*Ex. 28 days*)? \_\_\_\_\_

How many days does your period last (*how many days do you bleed?*) (*Ex. 5 days*) \_\_\_\_\_

How are your cramps?  Mild  Moderate  Severe

How heavy is your flow:  Light  Moderate  Heavy

Do you get spotting between your periods?  Yes  No

**No Periods:** When did you stop having periods (*age or what year?*) \_\_\_\_\_

Why are you not having periods?  Breastfeeding  IUD  Hormone pills/shots/implants;  Menopause  
 Surgery  Don't know

Have you ever taken menopausal hormone therapy?  Yes  No  Not applicable

### Gender Identity, Sexual Orientation, and Sexual Activity:

What is your gender identity:  Female  Male  Trans  Other \_\_\_\_\_

Are you sexually active?  Yes  No  Not currently

If yes, are your partners  Female  Male  Both

What do you use or do to prevent pregnancy? \_\_\_\_\_

Would you like to be tested for sexually transmitted diseases today?  Yes  No

PT.O

NAME

DOB

Place EPIC Label Within Box

#### UW Medicine

Harborview Medical Center – Northwest Hospital & Medical Center  
Valley Medical Center – UW Medical Center  
University of Washington Physicians Seattle, Washington

#### OBGYN NEW PATIENT INTAKE

Page 1 of 8



\*U3206\*

WHITE - MEDICAL RECORD

## Routine Health Care

Date of your last Pap test (*if >21 y.o.*): \_\_\_\_\_ Result:  Normal  Abnormal

Date of your last mammogram: \_\_\_\_\_ Result:  Normal  Abnormal

Date of your last colon cancer screening test: \_\_\_\_\_ Result:  Normal  Abnormal

Date of your last cholesterol blood test: \_\_\_\_\_ Result: \_\_\_\_\_

Have you had a bone density test?  Yes  No

Result: \_\_\_\_\_

## Symptom Review

*For each item below, please show whether you have had any recent problems by checking yes or no:*

<u>General</u>	YES	NO	<u>Lungs</u>	YES	NO
Unusual fatigue	_____	_____	Shortness of breath	_____	_____
Weight <b>gain</b> without trying	_____	_____	Cough	_____	_____
Weight <b>loss</b> without trying	_____	_____	Wheezing	_____	_____
Fevers	_____	_____	Apnea	_____	_____
<u>Eyes</u>			<u>Breast</u>		
Changes in vision	_____	_____	Breast mass	_____	_____
Eye pain	_____	_____	Nipple discharge	_____	_____
			Breast pain	_____	_____
<u>Head/Ears/Throat</u>			<u>Gastrointestinal</u>		
Ringing in ears	_____	_____	Abdominal pain/bloating	_____	_____
Hearing loss	_____	_____	Constipation	_____	_____
Sinus problems	_____	_____	Diarrhea	_____	_____
Sore throat	_____	_____	Acid reflux/heartburn	_____	_____
Hoarse voice	_____	_____	Blood in stool	_____	_____
			Poor control of stool	_____	_____
<u>Heart</u>			<u>Gynecologic</u>	YES	NO
Chest pain	_____	_____	Vaginal discharge	_____	_____
Palpitations	_____	_____	Abnormal vaginal bleeding	_____	_____
			Pelvic pain	_____	_____
			Pain with intercourse	_____	_____
			Premenstrual dysphoric disorder	_____	_____
			PMS	_____	_____

PT.NO

NAME

DOB

Place EPIC Label Within Box

**UW Medicine**  
 Harborview Medical Center – Northwest Hospital & Medical Center  
 Valley Medical Center – UW Medical Center  
 University of Washington Physicians      Seattle, Washington

**OBGYN NEW PATIENT INTAKE**

Page 2 of 8



\*U3206\*

WHITE - MEDICAL RECORD

**Urinary**                                **YES    NO**  
 Painful urination                                \_\_\_\_\_  
 Blood in urine                                    \_\_\_\_\_  
 Poor control of urine                            \_\_\_\_\_  
 Difficulty emptying bladder                    \_\_\_\_\_

**Joints/Bones/Muscles**  
 Joint pain                                         \_\_\_\_\_  
 Muscle or bone pain                             \_\_\_\_\_

**Skin**  
 Rash    \_\_\_\_\_  
 Changing mole(s)                                \_\_\_\_\_

**Neurologic**                                **YES    NO**  
 Headaches                                        \_\_\_\_\_  
 Loss of memory                                 \_\_\_\_\_  
 Weakness in limbs                               \_\_\_\_\_

**Blood/Lymph**                                **YES    NO**  
 Easy bruising/bleeding                        \_\_\_\_\_  
 Swollen lymph nodes                          \_\_\_\_\_

**Psychiatric**  
 Anxiety    \_\_\_\_\_  
 Depression                                        \_\_\_\_\_

**Glands/Endocrine**  
 Thirsty all the time                              \_\_\_\_\_  
 Can't stand the heat or cold                    \_\_\_\_\_  
 Hot flashes                                        \_\_\_\_\_  
 Abnormal hair growth                          \_\_\_\_\_

Do you have any other concerns that your provider should know about today?    \_\_ Yes    \_\_ No  
 Explain: \_\_\_\_\_  
 \_\_\_\_\_

**Allergies**

*Please list all allergies that you have (medications, food, etc.) and what reaction occurred:*

**No Allergies**

Medication or Substance	Reaction

PT.NO \_\_\_\_\_  
 \_\_\_\_\_  
 NAME \_\_\_\_\_  
 Place EPIC Label Within Box  
 \_\_\_\_\_  
 \_\_\_\_\_  
 DOB \_\_\_\_\_

**UW Medicine**  
 Harborview Medical Center – Northwest Hospital & Medical Center  
 Valley Medical Center – UW Medical Center  
 University of Washington Physicians                                        Seattle, Washington

**OBGYN NEW PATIENT INTAKE**

Page 3 of 8



\*U3206\*

WHITE - MEDICAL RECORD

Please list all medications you take, including vitamins, herbal or natural supplements, and prescription as well as over-the-counter medications, whether taken regularly or as-needed:

       **No Medications**

Medication Name	Dosage

<b>Social History &amp; Habits</b>
------------------------------------

<p><b>Smoking (mark one):</b>  <input type="checkbox"/> I have never smoked    <input type="checkbox"/> I'm a former smoker    <input type="checkbox"/> I'm a current smoker          If you used to smoke, when did you quit? _____          If you smoke now, how many years have you smoked? _____          Are you interested in quitting? <input type="checkbox"/> Yes <input type="checkbox"/> No          How many packs per day do you smoke? ¼ ½ 1 1½ 2 3 Other: _____</p>
<p><b>Smokeless tobacco (mark one):</b> <input type="checkbox"/> I have never used <input type="checkbox"/> I'm a former user <input type="checkbox"/> I'm a current user</p>
<p><b>Do you drink alcohol? (mark one):</b> <input type="checkbox"/> Yes <input type="checkbox"/> No          If yes, how many drinks per week? <input type="checkbox"/> Glasses of wine    <input type="checkbox"/> Cans of beer    <input type="checkbox"/> Shots of liquor</p>
<p><b>Do you use drugs? (mark one):</b> <input type="checkbox"/> Yes <input type="checkbox"/> No  <input type="checkbox"/> I used to in the past, but don't any longer          If yes, how many times per week? _____          Which drugs do you use? Marijuana _____ Other : _____</p>
<p>Have you ever been sexually, physically or emotionally abused? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Are you interested in counseling for any of the above?                      Yes <input type="checkbox"/> No <input type="checkbox"/></p>

PT.NO
NAME Place EPIC Label Within Box
DOB

**UW Medicine**

Harborview Medical Center – Northwest Hospital & Medical Center  
 Valley Medical Center – UW Medical Center  
 University of Washington Physicians                      Seattle, Washington

**OBGYN NEW PATIENT INTAKE**

Page 4 of 8



\*U3206\*

WHITE - MEDICAL RECORD

## Medical History

Please circle all of the following that you have had:

Abnormal Pap smear	COPD ( <i>emphysema</i> )	Genital Warts	Pelvic Pain
Abnormal uterine bleeding	Coronary or Heart Disease	GERD ( <i>acid reflux</i> )	PID ( <i>pelvic infection</i> )
Anemia	Deep vein thrombosis	Hepatitis	Pulmonary embolism
Anxiety	Depression	HIV	Seizures
Arthritis	Diabetes Type 2 ( <i>circle</i> ) Diet, pills, insulin	Hypertension	Sexually transmitted infection: ( <i>circle below</i> ) chlamydia, gonorrhea, trichomonas
Asthma	Diabetes Type 1	Infertility	Stroke
Blood Transfusion	Fibroids	Kidney Disease	Substance Abuse
Cancer (explain below)	Endometriosis	Lipid or cholesterol high	Thyroid disease
CHF (heart failure)	Fibroids	Migraine	Urinary incontinence
Clotting disorder	Genital Herpes	Osteoporosis	Urinary Tract infection

**Other medical conditions, or additional information about conditions above:**

---



---



---



---

PT.NO

NAME Place EPIC Label Within Box

DOB

**UW Medicine**

Harborview Medical Center – Northwest Hospital & Medical Center  
 Valley Medical Center – UW Medical Center  
 University of Washington Physicians      Seattle, Washington

**OBGYN NEW PATIENT INTAKE**

Page 5 of 8



\*U3206\*

WHITE - MEDICAL RECORD

## Surgical History

Please circle all of the following that you have had:

	Date		Date		Date
Abdomen surgery- Open		Cosmetic surgery		Induced Abortion	
Appendectomy		D&C		Myomectomy (removal of fibroids)	
Bladder suspension		Endometrial ablation		Ovary Removal	
Breast surgery		Gallbladder removal		Pelvic laparoscopy	
C-section		Hernia Repair		Tonsillectomy	
Cervical dysplasia treatment: (circle) freezing, LEEP, Cone, Laser		Hysterectomy: (circle) -Abdominal -Laparoscopic -Robotic -Vaginal		Tubal ligation	
Colon surgery		Hysteroscopy			

Other surgeries and procedures, or additional information about those circled above:

\_\_\_\_\_

\_\_\_\_\_

## Family History

Were you adopted?  Yes  No

Has anyone in your biological family had the following:

		Who? Ex. Mother, Maternal Aunt	Age			Who? Ex. Mother, Maternal Aunt	Age
Birth Defects / Twins	<input type="checkbox"/>				<input type="checkbox"/>		
Bleeding Disorder	<input type="checkbox"/>			Diabetes	<input type="checkbox"/>		
Blood Clots (leg, lung, etc)	<input type="checkbox"/>			Endometriosis Fibroids	<input type="checkbox"/>		
Breast Cancer	<input type="checkbox"/>			Heart disease	<input type="checkbox"/>		
Colon Cancer	<input type="checkbox"/>			High cholesterol	<input type="checkbox"/>		
Ovarian Cancer	<input type="checkbox"/>			Thyroid Disease	<input type="checkbox"/>		
Prostate Cancer	<input type="checkbox"/>			Osteoporosis	<input type="checkbox"/>		
Other Cancer:	<input type="checkbox"/>				<input type="checkbox"/>		
Other:	<input type="checkbox"/>				<input type="checkbox"/>		

PT.NO \_\_\_\_\_

NAME \_\_\_\_\_  
Place EPIC Label Within Box

DOB \_\_\_\_\_

### UW Medicine

Harborview Medical Center – Northwest Hospital & Medical Center  
 Valley Medical Center – UW Medical Center  
 University of Washington Physicians Seattle, Washington

### OBGYN NEW PATIENT INTAKE

Page 6 of 8



\*U3206\*

WHITE - MEDICAL RECORD

## Pregnancies and Deliveries

Have you ever been pregnant?  Yes  No *If no, skip section*

Total Pregnancies: \_\_\_\_\_ # of living children: \_\_\_\_\_

Please list all of your pregnancies in the table below including all miscarriages, ectopics and abortions.

Date of Delivery / Ectopic / Miscarriage	Gestational Age (in wks)	Outcome (Vaginal birth / cesarean / ectopic / miscarriage / etc.)	Weight	Gender	Hospital	Complications?
<i>Example: 4/2/96</i>	<i>38 weeks</i>	<i>Cesarean</i>	<i>6lbs 4oz</i>	<i>Boy</i>	<i>UWMC</i>	<i>No</i>

## Immunizations

Vaccine for:	Have you ever had this vaccine?	If yes, date(s):
HPV or Human papillomavirus (Gardasil or Cervarix)	Yes No Don't know	1. _____ 2. _____ 3. _____
Hepatitis B vaccine (HBV)	Yes No Don't know	1. _____ 2. _____ 3. _____
Influenza vaccine (Flu shot)	Yes No Don't know	Last dose: _____
Measles, mumps, & rubella (MMR)	Yes No Don't know	Last dose: _____
Tetanus/diphtheria (Td)	Yes No Don't know	Last dose: _____

PT.NO \_\_\_\_\_

NAME \_\_\_\_\_  
*Place EPIC Label Within Box*

DOB \_\_\_\_\_

**UW Medicine**  
 Harborview Medical Center – Northwest Hospital & Medical Center  
 Valley Medical Center – UW Medical Center  
 University of Washington Physicians      Seattle, Washington

**OBGYN NEW PATIENT INTAKE**

Page 7 of 8



\*U3206\*

WHITE - MEDICAL RECORD

**PHQ2:**

Over the past 2 weeks, how often have you been bothered by the following problems?

<i>Circle <u>one</u> number in each line</i>	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

**Safety and Work/Life**

Do you exercise?  Yes  No How many hours per week? \_\_\_\_\_

When biking, do you wear a helmet?  Yes  No

When driving, do you wear a seatbelt?  Yes  No

Where and with whom do you live? \_\_\_\_\_

Do you have trouble taking care of your daily activities? (Ex. Buying food)  Yes  No

Do you feel safe in your current living situation?  Yes  N

**How often does your partner or boss:** (Circle one number in each line)

	Never	Rarely	Sometimes	Fairly Often	Frequently
Physically hurt you	1	2	3	4	5
Insult or talk down to you	1	2	3	4	5
Threaten you with harm	1	2	3	4	5
Scream or curse at you	1	2	3	4	5

Total: \_\_\_\_\_

What is your profession / occupation? \_\_\_\_\_

For how long? \_\_\_\_\_

Were you forced into your line of work?  Yes  No

Is someone telling you that you owe them money and is using that to control you?  Yes  No

PATIENT SIGNATURE	PRINT NAME	DATE	
SUBMITTING STAFF SIGNATURE	PRINT NAME	DATE	TIME

PT.NO \_\_\_\_\_

NAME \_\_\_\_\_

Place EPIC Label Within Box

DOB \_\_\_\_\_

**UW Medicine**  
 Harborview Medical Center – Northwest Hospital & Medical Center  
 Valley Medical Center – UW Medical Center  
 University of Washington Physicians Seattle, Washington

**OBGYN NEW PATIENT INTAKE**

Page 8 of 8



\*U3206\*

WHITE - MEDICAL RECORD