# UW Medicine

## OB/GYN NEW PATIENT INTAKE

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

## 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 <u>each</u> item below, please show whether you have had any <u>recent</u> problems by checking yes or no:*

| **General** | **YES** | **NO** |
|---|---|---|
| Unusual fatigue | ____ | ____ |
| Weight **gain** without trying | ____ | ____ |
| Weight **loss** without trying | ____ | ____ |
| Fevers | ____ | ____ |

| **Eyes** | | |
|---|---|---|
| Changes in vision | ____ | ____ |
| Eye pain | ____ | ____ |

| **Head/Ears/Throat** | | |
|---|---|---|
| Ringing in ears | ____ | ____ |
| Hearing loss | ____ | ____ |
| Sinus problems | ____ | ____ |
| Sore throat | ____ | ____ |
| Hoarse voice | ____ | ____ |

| **Heart** | | |
|---|---|---|
| Chest pain | ____ | ____ |
| Palpitations | ____ | ____ |

| **Lungs** | **YES** | **NO** |
|---|---|---|
| Shortness of breath | ____ | ____ |
| Cough | ____ | ____ |
| Wheezing | ____ | ____ |
| Apnea | ____ | ____ |

| **Breast** | | |
|---|---|---|
| Breast mass | ____ | ____ |
| Nipple discharge | ____ | ____ |
| Breast pain | ____ | ____ |

| **Gastrointestinal** | | |
|---|---|---|
| Abdominal pain/bloating | ____ | ____ |
| Constipation | ____ | ____ |
| Diarrhea | ____ | ____ |
| Acid reflux/heartburn | ____ | ____ |
| Blood in stool | ____ | ____ |
| Poor control of stool | ____ | ____ |

| **Gynecologic** | **YES** | **NO** |
|---|---|---|
| Vaginal discharge | ____ | ____ |
| Abnormal vaginal bleeding | ____ | ____ |
| Pelvic pain | ____ | ____ |
| Pain with intercourse | ____ | ____ |
| Premenstrual dysphoric disorder PMS | ____ | ____ |

| **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 |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |

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*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 |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |

## Social History & Habits

**Smoking** *(mark one)*:

__I have never smoked __I'm a former smoker __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? __Yes __No

How many packs per day do you smoke? ¼ ½ 1 1½ 2 3 Other: _____

**Smokeless tobacco** *(mark one):* __I have never used __I'm a former user __I'm a current user

**Do you drink alcohol?** *(mark one)*: __ Yes __ No

If yes, how many drinks per week? __ Glasses of wine ____ Cans of beer ___ Shots of liquor

**Do you use drugs?** *(mark one)*: __ Yes __ No

__ 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 : _____

Have you ever been sexually, physically or emotionally abused? Yes__ No__

Are you interested in counseling for any of the above? Yes___ No___

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# Medical History

*Please circle all of the following that you have had:*

| | | | |
|---|---|---|---|
| Abnormal Pap smear | COPD *(emphysema)* | Genital Warts | Pelvic Pain |
| Abnormal uterine bleeding | Coronary or Heart Disease | GERD *(acid reflux)* | PID *(pelvic infection)* |
| Anemia | Deep vein thrombosis | Hepatitis | Pulmonary embolism |
| Anxiety | Depression | HIV | Seizures |
| Arthritis | Diabetes Type 2 *(circle)*<br>Diet, pills, insulin | Hypertension | Sexually transmitted infection: *(circle below)* chlamydia, gonorrhea, trichomonas |
| Asthma | Diabetes Type 1 | Infertility | Stroke |
| Blood Transfusion | Fibroids | Kidney Disease | Substance Abuse |
| Cancer<br>(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:**

_____

_____

_____

_____

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## 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 | | | | | | | |
| Bleeding Disorder | | | | Diabetes | | | |
| Blood Clots *(leg, lung, etc)* | | | | Endometriosis Fibroids | | | |
| Breast Cancer | | | | Heart disease | | | |
| Colon Cancer | | | | High cholesterol | | | |
| Ovarian Cancer | | | | Thyroid Disease | | | |
| Prostate Cancer | | | | Osteoporosis | | | |
| Other Cancer: | | | | | | | |
| Other: | | | | | | | |

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## 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? |
|---|---|---|---|---|---|---|
| *Example: 4/2/96* | *38 weeks* | *Cesarean* | *6lbs 4oz* | *Boy* | *UWMC* | *No* |
| | | | | | | |
| | | | | | | |
| | | | | | | |

## 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. _____<br>2. _____<br>3. _____ |
| Hepatitis B vaccine *(HBV)* | Yes No Don't know | 1. _____<br>2. _____<br>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: |

## PHQ2:

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

| *Circle one number in each line* | **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 |

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