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

PLACE PATIENT LABEL HERE

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	____	____

PLACE PATIENT LABEL HERE

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

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___

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)* 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 (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:

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:							

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. _____ 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:

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

PLACE PATIENT LABEL HERE