HealthCare Partners

Ph: (702) 255-3547
● Fx: (702) 736-2831

GYN – Women's Health Patient Intake History

Patient Name ___________________ **Birthdate** _____ / _____ / _____ **Today's Date** _____ / _____ / _____

☐ English ☐ Spanish ☐ Sign Language ☐

Social History

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Are you living alone? ☐ Yes ☐ No

Primary Language: Other: ____

Employment Status: ☐ Employed ☐ Unemployed ☐ Retired **Occupation**: ______________________________________

Tobacco Use: ☐ Yes ☐ No | **If yes, how much/how long (yrs)** _______ | ☐ Never a smoker ☐ Former smoker | How Long _____

Alcohol Use: ☐ Yes ☐ No | **If yes, how much/how often** ____________ | **Drug Use**: ☐ Yes ☐ No | If yes, how long ___________

Patient History

Current Medications (include prescriptions, vitamins, supplements, and over the counter medications), Attach separate sheet if needed:

Name & Strength of Rx	***Reason for Rx***	***Prescribing Physician***	***Date Prescribed***

Allergies

Do you have any allergies? ☐ Yes ☐ No

Do you have a latex allergy? ☐ Yes ☐ No | Reaction: ______________

Allergy: ___________________________________ | Reaction: ____

Allergy: ___________________________________ | Reaction: ____

Allergy: ___________________________________ | Reaction: ____

Allergy: ___________________________________ | Reaction: ____

Vaccines

Please tell us when you last had the following immunization(s):

Flu:	**Tdap (tetanus and/or diphtheria):**	**Gardasil (HPV):**
Pneumococcal:	**Zoster (Shingles):**	**Hepatitis B:**

Medical History

What medical problems have you had? Please mark all that apply:

✓	Condition	Onset Date	✓	Condition	Onset Date	✓	Condition	Onset Date
	Allergies			Diabetes			Trauma/Violence	
	Anemia/Hematologic			Heart Disease/ Stroke			Uterine Abnormalities	
	Asthma/ Pulmonary			Hypertension			Varicosities/ Blood clots	
	Autoimmune Disorder			Infertility			Anesthesia Complications	

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Patient Label

	Abnormal Pap Smears			Liver Disease			Cancer	
	Blood Transfusions			Neurologic Disorder Epilepsy/Headache/Migraine			*Other:*	
	Breast Disorders			GI/Stomach Kidney/Bladder				
	Depression/ Psychiatric			Rh Sensitized				
	Skin Disorder			Thyroid Disorder				

Surgical History

What surgeries have you had? Please mark all that apply and include the year they were performed:

✓	Condition	Date	✓	Condition	Date	✓	Condition	Date
	Appendectomy			Gall Bladder Removal			Lasik	
	Arthroscopy			Colectomy (Colon removal)			Liver Biopsy	
	Back Surgery			Colostomy			Thyroidectomy	
	Heart Procedure/Surgery			Gastric Bypass			Tonsillectomy	
	Cardiac Pacemaker			Hernia Repair			*Other:*	
	Carpal Tunnel Surgery			Hip Replacement				
	Cataract Extraction			Knee Replacement				

Female-specific surgeries:

	Breast Implants (Augmentation)			Mastectomy			Removal of Ovaries	
	Breast Reduction			Uterine Fibroids Removed (Myomectomy)			Removal of Fallopian Tubes	
	Breast Biopsy			Hysterectomy			Bladder	

Diagnostic Tests and Hospitalizations

Enter the last completion date and whether the result was normal:

Test	Date	Normal (Y/N)	Test	Date	Normal (Y/N)
Bone Density			Pap Smear (Female Only)		
Colonoscopy			Mammogram (Female Only)		
Other:					

Have you had any recent hospitalizations or ER visits? Provide dates and reason below:

Date	Reason	Hospital	Date	Reason	Hospital

Pregnancy History

Number of Pregnancies ________ Number of Births ________ Number of Full Term Births ________

Number of Pre-Term Births ________ Number of Abortions ________ Number of Miscarriages ________

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Patient Label

Provider Use: G__ P __ __ __ __ __

Number of Living Children _________ Number of Cesarean Sections _________

☐ None ☐ Mild ☐

Menstrual History

Are you having periods? __ **Yes** __ **No**

If Yes, date of last menstrual period ______________________

Age of first menstrual period ____________________________

# of days between each cycle ___________________________

Are your cycles regular each month? ☐ Yes ☐ No

# of days bleeding occurs _______________________________

☐ Light ☐ Medium ☐ Heavy ☐ Flood ☐ Amount of bleeding: Clots

Pain/cramps during menstrual period: Severe

If No, due to menopause? ☐ Yes ☐ No | If no, why _________

If yes, when did menopause start ______________________

☐ Natural Menopause ☐ Surgical Menopause

Any bleeding since menopause? ☐ Yes ☐ No

If yes, when _______________ How much _______________

Are you taking Hormone Replacement Therapy? ☐ Yes ☐ No

Sexual History

Are you currently sexually active? ☐ **Yes** ☐ **No**

# of partners in the past year _____

Partner genders: ☐ Men ☐ Women ☐ Both

Do you want to be pregnant? ☐ Yes ☐ No

If no, is it by choice? ☐ Yes ☐ No

Is there a problem th from having intercourse? ☐ Yes ☐ No

If yes, please explain: __________________________________

If no, how do prevent from becoming pregnant?

☐ Condoms

☐ IUD, type: ______________________________________

☐ Tubal Ligation/Essure

☐ No Contraception

☐ Birth Control Pills/Patch/Ring

☐ Nexplanon

☐ Partner had vasectomy

☐ Other: ______________________________________

Any problems with intercourse? ____

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Patient Label

Family History

List health conditions for each family member:

Family Member	Alive	Deceased	Age at time of Death	Health Condition(s)
Father				
Mother				
Brothers				
Sisters				
Maternal Grandmother				
Maternal Grandfather				
Paternal Grandmother				
Paternal Grandfather				

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of Healthcare Partners responsible for any errors or omissions that I may have made in the completion of this form.

____

Patient or Parent/Guardian Printed Name

____ ____________________________

Patient or Parent/Guardian Signature Today’s Date