St. Luke's OB/GYN Patient Intake Form

Today's date: __/__/_____ Name: _____ DOB ___/___/_____

Reason for visit: _____ Your primary care MD: _____

YOUR PERSONAL HEALTH HISTORY

Medications – Any changes to your current med list?

_____

Any med allergies/reactions? _____

Medical history – please check if you have or have had in the past

___Asthma ___Depression ___Thyroid Disorder ___High blood pressure ___Diabetes

___GERD ___Heart disease ___Arthritis ___Other medical problem; please explain:

___Personal history of cancer If yes, what type _____

Breast Health History: Any current breast concerns? Yes or no; Describe: _____

Last screening mammogram: _____ Done at St. Luke's or _____ No previous mammogram ____

Month / Year

Abnormal mammogram: If yes, date ___/___/_____

Any prior breast biopsies: yes or no If yes, date __/__/____ and where done: St. Luke's or _____

Surgical History: Please list all, including dates _____

_____

Have you had a colonoscopy? Yes or No Date: _____/_____ Result: Normal / Abnormal

Month Year

Gynecologic History:

Please check (X) if you have had in the past

___Abnormal pap test / colposcopy ____Problems with birth control ____Problems getting pregnant

___Sexually transmitted infection ____Other gynecologic problems – Explain: _____

HRT use? (hormone replacement therapy) *Circle one:* Never 5 or more years ago Less than 5 years ago Current

Length of HRT use (years) _____ Intended length of use (years)_____

Sexual History:

Are you currently in a sexual relationship? Yes / No If yes, your partner(s): Male Female Both Other

Method of birth control: _____ Do you plan pregnancy in future? Yes / No

Menstrual history:

Age at first period: ____ **First day of your last period: ___/___/____** How often do you get your periods? _____

Do you bleed between periods? Yes / No Do you have heavy bleeding? Yes / No Do you have clots? Yes / No

Is your period painful? Yes/ No Length of period: _____ Age at menopause: _____

Pregnancy History:

Date	Outcome V = Vaginal Birth C = Cesarean M = Miscarriage E = Ectopic A = Abortion	How many weeks pregnant at time of delivery? (40 weeks=Full term)	Baby's sex	Baby's weight	Location of Delivery and/or Physician's name

FAMILY MEDICAL HISTORY

Please check (X) for any of the following that has been experienced by a family member:

_____Breast cancer: If yes, please circle and note age of diagnosis

Mother, age____ Sister, age____ Maternal Grandmother, age____ Paternal Grandmother, age____
Maternal Aunts, age____ Paternal Aunts, age ____ Daughter, age____ Father, age____
Brother, age ____ Cousin, age____

_____Ovarian cancer: If yes, please circle and note age of diagnosis

Mother, age____ Sister, age____ Maternal Grandmother, age____ Paternal Grandmother, age____
Maternal Aunts, age____ Paternal Aunts, age ____ Daughter, age____ Cousin, age____

____Colon cancer ____Diabetes ____Heart Disease ____Clotting Disorder: If yes, please circle and note age of diagnosis Mother, age___ Father, age___ Sibling, age___

____Do not know my family history

YOUR PERSONAL SOCIAL HISTORY

Occupation: _____ Education: _____
Marital status: (circle one) Single Married Partnered Divorced Widowed
Have you ever been hurt by someone? Yes / No Physically or Mentally/Emotionally
Do you feel safe? Yes / No
Alcohol use: Yes / No / I used to Number of drinks per day: _____
Tobacco use: Yes / No / I used to Cigarettes per day: _____
Drug use: Yes / No / I used to
Do you exercise regularly? Yes / No Days per week: _____ Usual Activity: _____
Calcium intake: ___ Through diet ___ Through supplements
Vitamin D intake: ___ Through diet ___ Through supplements
Do you have any Ashkenazi Jewish Heritage? Yes or No
Do you have an advanced care directive on file at St. Luke's? Yes No
If not, would you like information about this? Yes No

REVIEW OF SYSTEMS - Please circle any symptoms that you are currently experiencing:

Constitutional:	fatigue fever weight loss weight gain other
Eyes:	change in vision
ENT:	sinus problems dental problems
Cardiovascular:	chest pain leg swelling difficulty breathing with exertion
Respiratory:	cough shortness of breath wheezing
Gastrointestinal:	constipation diarrhea nausea vomiting bloody stools
Urinary:	bloody urine urinary frequency involuntary loss of urine (incontinence) difficulty urinating
Genitourinary:	heavy periods pain with intercourse painful periods pelvic pain abnormal vaginal discharge irregular periods vulvar (external) irritation/itching
Musculoskeletal:	back pain joint swelling arthritis other
Breast:	breast pain skin changes nipple discharge lumps
Neurologic:	dizziness headaches seizures migraines
Psychiatric:	anxiety depression PMS frequent crying
Hematology/Lymph:	excessive bleeding (with skin injury, dental work, or surgery) bruises easily other
Endocrine:	hot flashes other
Allergic:	allergy symptoms other

Completed by (print name): _____ Date: ___/ ___ /_____

Signature: _____