SARATOGA HOSPITAL
MEDICAL GROUP
MIDWIFERY AND WOMEN'S HEALTH SERVICES

Gynecology Intake and History Form:

Today's Date: _____

Name: _____ Date of Birth: _____

Primary Care Provider: _____

Reason for Visit: _____

List all current medications (including vitamins and over the counter meds) and the dosage you are taking:_____
_____
_____

Allergies:_____
_____
_____

Please list any surgeries, procedures, and hospitalizations (please include dates):_____
_____
_____

GYN History: (Please answer all the apply)

Age of first menstrual period:	Are your periods painful?	Are you sexually active?
First day of last period:	Other Menstrual Symptoms:	Is intercourse painful?
How many day does period last?	Any Vaginal itching or burning?	Total # of sexual partners in lifetime:
How many days between periods?	Have you had the HPV/Gardasil vaccine series? If yes how many shots?	# of male partners: #of female partners:
Is your flow heavy, light, or moderate?	Do you have any history of STDs? If yes, please describe:	Have you ever had an abnormal pap or procedure (i.e. colposcopy, LEEP) on your cervix? If yes, please describe:

Self-Care:

Date of last Physical Exam:	Date of last pelvic/pap exam:	Date of last colonoscopy:
Date of last breast exam:	Date of last Mammogram:	Other testing:
Do you do self-breast exams?	Date of last Bone Density Scan:	Current Birth Control Method:

Menopause History: (Please answer all that apply):

Age at Menopause: Symptoms of Menopause:	Are you currently or have you ever taken hormones? If yes: what did you take, when did you take them, and for how long?
If you have had a hysterectomy, do you still have your ovaries?	Are there any side effects?

Current/Past Medical Problems/Diagnosis:

Diabetes Yes No

High Blood Pressure Yes No

Anxiety Yes No

Depression Yes No

Thyroid Disorders Yes No Please Specify if yes:_____

Do you have any other chronic Illnesses? Yes___ No___

If yes, please list: _____

Infection History:

Have you been exposed to Hepatitis B? Have you received the Hepatitis B Vaccination Series?	Possible exposure of Fifth's Disease?	Rash or viral illness since last menstrual period?
Any exposure to Tuberculosis?	History of Chicken Pox? Do you receive the Chicken Pox Vaccine?	History of MRSA?

Obstetric History

When was you last menstrual period? _____

Was it "normal" (came when expected, usual length, usual flow)? _____
If no please explain: _____

Were you planning a pregnancy at this time? _____

Were you using a method of birth control when you conceived? _____

How many times have you been pregnant?	Have you had any miscarriages? If so, how many?	Have you had any abortions? If so, how many?
How many full term deliveries?	Have you had any still births? If so, how many?	Have you had an ectopic pregnancy? If so, how many?
How many pre-term deliveries (before 37 weeks)?	Any history of pre-term labor?	

Please list and provide information on past deliveries you may have had:

Date of Delivery	Sex	Weight	Length of Labor	Pre-Term Labor?	Vaginal or C-Section	Any complications with pregnancy or delivery? If yes please explain.

Social History:

Marital Status: _____
Partner's name and occupation (if involved):_____
With whom do you live? _____
Are you employed? If so, what is your occupation? _____
Do you exercise? If so how often? _____
Do you use tobacco products? NO YES
Do you consume Alcohol? NO YES
Do you use Illicit Recreational Drugs? NO YES

Family History:

	Father	**Mother**	**Grandparents**	**Siblings**	**Children**
Diabetes					
Heart Disease					
Hypertension					
High Cholesterol					
Asthma					
Stroke					
Cancer					
Mental Illness					
Deceased					

Any other concerns or questions for today's visit?:

_____
_____
_____
_____