

# NORTHLAND OB-GYN INTAKE HISTORY

NAME \_\_\_\_\_ D.O.B. \_\_\_\_/\_\_\_\_/\_\_\_\_ DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

DRUG ALLERGIES/REACTION: \_\_\_\_\_

**MEDICAL HISTORY**

Please check if you have had in the past:

- Breast disorders
- Asthma
- Heart disease
- High blood pressure
- Gynecologic problems
- Abnormal mammogram

History of abnormal pap test/colposcopy/  
cervical procedures:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

History of sexually transmitted infection

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**CURRENT MEDICATIONS - (NAME & DOSE)**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Primary MD name \_\_\_\_\_

**FAMILY HISTORY**

I do not know family history

Illness	yes/no	relative
Breast cancer	_____	_____
Ovarian cancer	_____	_____
Colon cancer	_____	_____
Diabetes	_____	_____
Heart disease	_____	_____
Clotting disorder	_____	_____

**SURGERY HISTORY - LIST ALL, INCLUDE DATE**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Colonoscopy Y/N Date \_\_\_\_\_ Result \_\_\_\_\_

**OBGYN HISTORY**

Menstrual history:

First day of last menstrual period/year of last period if  
menopausal \_\_\_\_\_

Age at first period \_\_\_\_\_

How often do you get your periods \_\_\_\_\_

How many days of flow \_\_\_\_\_

Breakthrough bleeding? \_\_\_\_\_

Clots? \_\_\_\_\_

Are you currently in a sexual relationship? \_\_\_\_\_

Your partner: male/female \_\_\_\_\_

Method of birth control \_\_\_\_\_

**PREGNANCY HISTORY**

Number of pregnancies: \_\_\_\_\_

Date of birth/miscarriage/abortion \_\_\_\_\_

Gestational age \_\_\_\_\_

Weight \_\_\_\_\_ Sex \_\_\_\_\_ cesarean or vaginal

Anesthesia \_\_\_\_\_ MD \_\_\_\_\_

Date of birth/miscarriage/abortion \_\_\_\_\_

Gestational age \_\_\_\_\_

Weight \_\_\_\_\_ Sex \_\_\_\_\_ cesarean or vaginal

Anesthesia \_\_\_\_\_ MD \_\_\_\_\_

Date of birth/miscarriage/abortion \_\_\_\_\_

Gestational age \_\_\_\_\_

Weight \_\_\_\_\_ Sex \_\_\_\_\_ cesarean or vaginal

Anesthesia \_\_\_\_\_ MD \_\_\_\_\_

Date of birth/miscarriage/abortion \_\_\_\_\_

Gestational age \_\_\_\_\_

Weight \_\_\_\_\_ Sex \_\_\_\_\_ cesarean or vaginal

Anesthesia \_\_\_\_\_ MD \_\_\_\_\_

**SOCIAL HISTORY**

Education: \_\_\_\_\_

Occupation: \_\_\_\_\_

Marital status:

single married partnered divorced widowed

Have you ever been threatened, hit slapped, kicked by  
anyone you know? \_\_\_\_\_

**HABITS**

Alcohol Y/N/former \_\_\_\_\_ drinks/week

Tobacco Y/N/former \_\_\_\_\_ drinks/week

Drug use Y/N/former \_\_\_\_\_

Regular exercise: \_\_\_\_\_

Calcium intake: through diet/through supplement

**NOTES**

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\_\_\_\_\_

**REVIEW OF SYSTEMS**

Check if any of the following apply to you NOW:

**Constitutional:**

- Fatigue
- Fever
- Weight loss
- Weight gain

**Eyes:**

- Double vision
- Spots before eyes
- Visual changes

**ENT/mouth:**

- Sinus problems
- Dental problems

**Breast:**

- Lumps
- Pain
- Nipple discharge
- Skin change

**Cardiovascular:**

- Chest pain
- Difficulty breathing with exertion
- Leg swelling

**Respiratory:**

- Wheezing
- Shortness of breath
- Chronic cough

**Gastrointestinal:**

- Diarrhea
- Nausea/Vomiting
- Constipation
- Bloody stool

**Genitourinary:**

- Irregular periods
- Infrequent periods
- Painful periods
- Pelvic pain
- Pain with intercourse
- Bloody urine
- Difficulty urinating
- Involuntary loss of urine
- Urinary frequency

**Neurological:**

- Headaches
- Migraines
- Seizures
- Dizziness

**Musculoskeletal:**

- Back pain
- Other joint pain
- Arthritis

**Endocrine:**

- Hot flashes
- Abnormal thirst

**Psychiatric:**

- Frequent crying
- Depression
- PMS
- Anxiety

**Hemelymph:**

- Excessive bleeding with skin injury, dental work
- Easy bruising

**Allergic:**

- Sinus allergy symptoms

**NOTES**

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Completed by \_\_\_\_\_

Signature \_\_\_\_\_

Date reviewed with patient \_\_\_\_\_

MD signature \_\_\_\_\_

Annual review \_\_\_\_\_