**Obstetrics & Gynecology Intake Form**

***We would like to welcome you to Northern Virginia Physicians to Women. Please take a few minutes to tell us about yourself and your medical history so that we may provide you with the best care possible. Please be sure to complete this form to the best of your knowledge. If you have any questions, don't hesitate to ask for assistance from the receptionist.***

Patient Name: _____ Date: ____/____/____

Height:_____ Weight: _____

What brings you to our office today: _____

_____

**CURRENT MEDICATIONS**

| DRUG NAME | DOSE | DRUG NAME | DOSE |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**ALLERGIES**

| List drug, environmental, and food allergies | Reaction |
|---|---|
| | |
| | |
| | |
| | |

**GYN HISTORY**

What is the first day of your last menstrual period? _____

How long did it last? _____

Do you have heavy periods? ☐Yes ☐No

When was your last pap smear? _____ What was the result? _____

Have you ever had an abnormal pap? ☐Yes ☐No

If so, when? _____ What was the abnormality? _____

Have you ever had the following:

☐Colposcopy - Date:___/___/___ ☐Cryosurgery - Date: ___/___/___ ☐LEEP - Date: ___/___/___

**OB/GYN HISTORY**

| | NUMBER | | NUMBER |
|---|---|---|---|
| Birth(s) | | Abortion(s) | |
| Miscarriage(s) | | Living Children | |

| Delivery Date | Birth Weight | Sex of Baby | Vaginal/C-sec | Anesthesia | Name of Baby | Hospital/City |
|---|---|---|---|---|---|---|
| | | | | | | |

**OPERATIONS / HOSPITALIZATIONS**

| Hospitalization | Date | Operation | Date |
|---|---|---|---|
| | | | |

**FAMILY HISTORY**

| Illness | Yes | No | Family Member | Age of Diagnosis |
|---|---|---|---|---|
| Diabetes | | | | |
| Stroke | | | | |
| Heart Disease | | | | |
| Hypertension | | | | |
| Drinking Problem | | | | |
| Breast Cancer | | | | |
| Cancer ☐ovarian ☐colon ☐other | | | | |

☐ I AM ADOPTED

**SOCIAL HISTORY**

| Personal Habits | Current | Former | Never | Notes |
|---|---|---|---|---|
| Alcohol | | | | # drinks per week: # drinks per day: |
| Drug Use | | | | |
| Tobacco | | | | # packs per day: Age started: Age quit: |
| Seat Belt Use | | | | |
| Regular Exercise | | | | Type of exercise: |

**PERSONAL PROFILE**

| |
|---|
| Marital Status: ☐single ☐dating ☐engaged ☐married ☐widowed ☐divorced |
| Number of Living Children: Number of people in household: |
| Highest Education level completed: ☐high school ☐college ☐graduate / studies degree ☐other _____ |
| Current Job: |

**PERSONAL SAFETY**

| | Yes | No |
|---|---|---|
| Has anyone close to you ever threatened to hurt you? | | |
| Has anyone ever hit, kicked, choked, or hurt you physically? | | |
| Has anyone, including your partner, ever forced you to have sex? | | |
| Are you afraid of your partner? | | |
| Please check off any of the following you have been treated for:<br>☐vaginosis ☐genital warts ☐chlamydia ☐trichomoniasis ☐gonorrhea ☐syphilis | | |
| | Yes | No |
| Did you begin sexual activity before you were 18 years old? | | |
| Are you currently sexually active? ☐never | | |
| Have you had more than 5 sexual partners | | |
| Are you currently using birth control?<br>If yes, method of birth control _____ | | |
| Have you ever tested ***POSITIVE*** for the ***HIV*** virus (the human immunodeficiency virus) | | |

| | | |
|---|---|---|
| Did your mother take the drug DES when was pregnant with you | | |

**REVIEW OF SYSTEMS**

***Check all of the conditions that you are CURRENTLY having. Include ONLY present conditions.***

| Condition | Yes | Notes | Condition | Yes | Notes |
|---|---|---|---|---|---|
| Fever | | | Blood in Urine | | |
| Fatigue | | | Pain with urination | | |
| Weight loss | | | Urinary Frequency | | |
| Weight gain | | | Urinary Urgency | | |
| Vision problems | | | Incomplete empty | | |
| Sore throat | | | Stress Incontinence | | |
| Sinus problems | | | Abnormal Periods | | |
| Chest pain | | | Painful Intercourse | | |
| Difficulty breathing | | | Muscle Weakness | | |
| Swelling of legs | | | Pain in Breast | | |
| Heart Palpitations | | | Breast Discharge | | |
| Wheezing | | | Breast Masses | | |
| Coughing blood | | | Breast Rash | | |
| Shortness of breath | | | Dizziness | | |
| Chronic Cough | | | Seizures | | |
| Frequent Diarrhea | | | Numbness | | |
| Blood in Stool | | | Difficulty Walking | | |
| Nausea | | | Depression | | |
| Vomiting | | | Anxiety | | |
| Constipation | | | Dry Skin | | |
| Frequent Bruising | | | Abnormal Thirst | | |
| Enlarged Glands | | | Hot Flashes | | |

**PAST PERSONAL HISTORY**

| Yes | | Yes | | Yes | |
|---|---|---|---|---|---|
| | Asthma | | Cancer | | Fibroids |
| | Pneumonia | | Ulcers | | Endometriosis |
| | Chronic Lung Disease | | Depression/ Anxiety | | Ovarian Cyst |
| | Kidney Infection/ Stones | | Anemia / Blood Transfusions | | Osteopenia |
| | Tuberculosis | | Seizures/ Epilepsy | | Osteoporosis |
| | Venereal Disease | | Bowel Trouble | | GI Disease |
| | Heart Trouble/ Murmur | | Glaucoma | | GI Reflux |
| | Diabetes | | Arthritis | | Heart Disease |
| | High Blood Pressure | | Fracture | | Clotting Disorder |
| | Stroke | | Hepatitis/ Yellow Jaundice | | Other: |
| | Rheumatic Fever | | Thyroid Disease | | |

Completed by: ☐Patient ☐Nurse ☐Physician

Signature of Patient _____