

ALEXANDRIA WOMEN'S CENTER
Gynecologic Intake History

NAME: _____ BIRTH DATE: ____/____/____ DATE: ____/____/____

ADDRESS: _____

CITY: _____ STATE/ZIP: _____

HOME TEL: (____) _____ WORK TEL: (____) _____

EMPLOYER: _____ INSURANCE: _____

NAME OF SPOUSE/PARTNER: _____ REFERRED BY: _____

REVIEW OF SYSTEMS

PLEASE CHECK (X) IF ANY OF THE FOLLOWING APPLY TO YOU NOW, IN THE PAST OR OFTEN			
	CURRENTLY	PAST	NOTES
1. CONSTITUTIONAL			
Weight loss	<input type="checkbox"/>	<input type="checkbox"/>	
Weight gain	<input type="checkbox"/>	<input type="checkbox"/>	
Fever	<input type="checkbox"/>	<input type="checkbox"/>	
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	
2. EYES			
Double vision	<input type="checkbox"/>	<input type="checkbox"/>	
Spots before eyes	<input type="checkbox"/>	<input type="checkbox"/>	
Vision changes	<input type="checkbox"/>	<input type="checkbox"/>	
3. ENT/MOUTH			
Ear aches	<input type="checkbox"/>	<input type="checkbox"/>	
Ringing in ears	<input type="checkbox"/>	<input type="checkbox"/>	
Sinus problems	<input type="checkbox"/>	<input type="checkbox"/>	
Sore throat	<input type="checkbox"/>	<input type="checkbox"/>	
Mouth sores	<input type="checkbox"/>	<input type="checkbox"/>	
Dental problems	<input type="checkbox"/>	<input type="checkbox"/>	
4. CARDIOVASCULAR			
Painful breathing	<input type="checkbox"/>	<input type="checkbox"/>	
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	
Difficult breathing on exertion	<input type="checkbox"/>	<input type="checkbox"/>	
Swelling of legs	<input type="checkbox"/>	<input type="checkbox"/>	
Palpitations of heart	<input type="checkbox"/>	<input type="checkbox"/>	
5. RESPIRATORY			
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	
Spitting up blood	<input type="checkbox"/>	<input type="checkbox"/>	
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	
Cough, chronic	<input type="checkbox"/>	<input type="checkbox"/>	
6. GASTROINTESTINAL			
Diarrhea, frequent	<input type="checkbox"/>	<input type="checkbox"/>	
Bloody stool	<input type="checkbox"/>	<input type="checkbox"/>	
Nausea/vomiting	<input type="checkbox"/>	<input type="checkbox"/>	
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	
7. GENITOURINARY			
Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>	
Pain with urination	<input type="checkbox"/>	<input type="checkbox"/>	
Urgency	<input type="checkbox"/>	<input type="checkbox"/>	
Frequency of urination	<input type="checkbox"/>	<input type="checkbox"/>	
Incomplete emptying	<input type="checkbox"/>	<input type="checkbox"/>	
Stress incontinence	<input type="checkbox"/>	<input type="checkbox"/>	
Abnormal periods	<input type="checkbox"/>	<input type="checkbox"/>	
Painful intercourse	<input type="checkbox"/>	<input type="checkbox"/>	
8. MUSCULOSKELETAL			
Muscle weakness	<input type="checkbox"/>	<input type="checkbox"/>	

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PLEASE CHECK (X) IF ANY OF THE FOLLOWING APPLY TO YOU NOW, IN THE PAST OR OFTEN			
9. SKIN/BREAST	CURRENTLY	PAST	NOTES
Pain in breast	<input type="checkbox"/>	<input type="checkbox"/>	
Discharge	<input type="checkbox"/>	<input type="checkbox"/>	
Masses	<input type="checkbox"/>	<input type="checkbox"/>	
Rash	<input type="checkbox"/>	<input type="checkbox"/>	
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	
10. NEUROLOGICAL			
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	
Numbness	<input type="checkbox"/>	<input type="checkbox"/>	
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	
Trouble Walking	<input type="checkbox"/>	<input type="checkbox"/>	
11. PSYCHIATRIC			
Depression	<input type="checkbox"/>	<input type="checkbox"/>	
Crying, frequent	<input type="checkbox"/>	<input type="checkbox"/>	
12. ENDOCRINE			
Dry skin	<input type="checkbox"/>	<input type="checkbox"/>	
Abnormal thirst	<input type="checkbox"/>	<input type="checkbox"/>	
Hot flashes	<input type="checkbox"/>	<input type="checkbox"/>	
13. HEMATOLOGICAL/LYMPHATIC			
Bruises, frequent	<input type="checkbox"/>	<input type="checkbox"/>	
Cuts do not stop bleeding	<input type="checkbox"/>	<input type="checkbox"/>	
Enlarged lymph node	<input type="checkbox"/>	<input type="checkbox"/>	
14. ALLERGIC/IMMUNOLOGIC			
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	
Drugs, other	<input type="checkbox"/>	<input type="checkbox"/>	

PERSONAL PAST HISTORY

MAJOR ILLNESSES	YES	NO	MAJOR ILLNESSES	YES	NO
Asthma			Cancer		
Pneumonia			Ulcers		
Chronic lung disease			Depression/anxiety		
Kidney infections/stones			Anemia/Blood transfusions		
Tuberculosis			Seizures/convulsions/epilepsy		
Veneral disease			Bowel trouble		
Heart trouble/murmur			Glaucoma		
Diabetes			Arthirits/joint pain		
High blood pressure			Fracture		
Stroke			Hepatitis/Yellow jaundice		

OPERATIONS/HOSPITALIZATIONS

Reason	DATE	Reason	DATE

INJURIES/ILLNESSES

Type	DATE	Type	DATE

LAST IMMUNIZATION OR TEST

	DATE		DATE
Tetanus		Pneumonia	
Flu shot		TB Skin Test	

OB/GYN HISTORY

	NUMBER		NUMBER
Births		Abortions	
Miscarriages		Living children	

ALEXANDRIA WOMEN'S CENTER

CURRENT MEDICATION			
DRUG NAME	DOSAGE	DRUG NAME	DOSAGE

FAMILY HISTORY

ILLNESS	YES	RELATIVE	ILLNESS	YES	RELATIVE

FAMILY HISTORY

HABITS							
Smoking	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Packs per day _____	Years _____			
Alcohol	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Drinks per day _____	Drinks per week _____			
Drug use	Yes <input type="checkbox"/>	No <input type="checkbox"/>					
Seat belt use	Yes <input type="checkbox"/>	No <input type="checkbox"/>					
Regular Exercise	Yes <input type="checkbox"/>	No <input type="checkbox"/>					
PERSONAL PROFILE							
Marital Status	Married <input type="checkbox"/>	Single <input type="checkbox"/>	Widowed <input type="checkbox"/>	Divorced <input type="checkbox"/>			
Number of living children _____							
Number of people in household _____							
School completed	Highschool <input type="checkbox"/>	College <input type="checkbox"/>	Graduate degree <input type="checkbox"/>	Other <input type="checkbox"/>			
Current or most recent job _____							

FAMILY HISTORY

<input type="checkbox"/>	Has anyone close to you ever threatened to hurt you?
<input type="checkbox"/>	Has anyone ever kicked, choked, or hurt you physically?
<input type="checkbox"/>	Has anyone, including your partner, ever forced you to have sex?
<input type="checkbox"/>	Are you ever afraid of your partner?

Completed by: Patient Office Nurse Physician

SIGNATURE OF PATIENT: _____

DATE REVIEWED BY PHYSICIAN WITH PATIENT: _____

PHYSICIAN SIGNATURE: _____

ANNUAL REVIEW OF HISTORY _____

DATE REVIEWED: _____ DATE REVIEWED: _____

DATE REVIEWED: _____ DATE REVIEWED: _____

DATE REVIEWED: _____ DATE REVIEWED: _____

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