Perennial Women's Wellness
Gynecology Intake Form

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Date: ____/____/____ Name: _____ DOB: _____ Age: _____
Primary Care Physician: _____ Pharmacy: _____
Reason for Today's Visit: _____

*NOTE: Perennial Women's Wellness wants you to feel satisfied that your appointment has been productive and that you have been able to express and concerns you have. This form is to help us focus your appointment on the top 1-2 specific things you most want to discuss today. We realize there may be other topics you would like to cover for which we will gladly make you a second appointment if needed.

Allergies and Reaction

_____ _____
_____ _____

Medications

Drug Name	Dosage (MG)	Frequency	Drug Name	Dosage (MG)	Frequency

Gynecological History

Menstrual History
What is the first day of your last menstrual period? _____ How long does it last? _____
How many days apart are your menstrual cycles starting from the first day of one cycle to the first day of your next cycle? _____ Are your periods heavy? _____ How may heavy days? _____
Do you experience clots? _____ Cramping? _____
Do your periods interrupt your daily activities? _____ What age did you start having menses? _____

When was your last pap smear? _____
Have you ever had an abnormal pap? _____ If yes when? _____ What abnormality? _____

Have you ever been treated for
Chlamydia Gonorrhea Genital Warts Herpes Trichomonas Syphilis
Have you ever tested positive for HIV? No Yes

Are you currently sexually active: Yes No Never Sexual Orientation: _____
Did you begin sexual activity before the age of 16? No Yes If yes age started: _____
Have you had >5 sexual partners in your lifetime? No Yes If yes, how many? _____
Have you had the HPV Vaccine Gardasil? _____

Are you currently using birth control? Yes No Trying to get pregnant

Current birth control method: _____ Are you satisfied with it? _____

Past Birth Control Methods:

Condoms Birth Control Pills Withdrawl Tubal Ligation Diaphragm Patch Depo Injection

Rhythm Vasectomy Vaginal Film Vaginal Ring IUD Essure

Personal Medical History

Major Illnesses	Yes	Major Illnesses	Yes	Major Illnesses	Yes		Yes
Diabetes		High Blood Pressure		Osteopenia		Other GI Disease	
Fibroids		Endometriosis		Osteoporosis		Liver Problems	
Heart Disease		High Cholesterol		Hepatitis		Anxiety	
Arthritis		Joint Pain		Fracture		Depression	
Seizures		Asthma		Lung Disease		Anemia	
Tuberculosis		Thyroid Disease		Clotting Disorder			
Kidney Infections/Stones		GI Reflux Disease		Cancer (Type:)			

Others

Explain:_____

Surgical History

Surgery	Year	Surgery	Year

Preventative Screenings

When was your last mammogram? _____ Where? _____ Was it normal? _____

Have you ever had a bone density (DEXA)? _____ When/Where? _____ Result? _____

Have you ever had a colonoscopy? _____ When?: _____ Result: _____

Family History

Major Illnesses	Relation	Major Illness	Relation
Diabetes		High Blood Pressure	
GI Reflux Disease		Fibroids	
Endometriosis		Osteopenia/Osteoporosis	
Heart Disease		High Cholesterol	
Hepatitis/Liver Disease		Arthritis/Joint Pain	
Anxiety/Depression		Seizures	
Asthma/Lung Disease		Tuberculosis	
Stroke		Clotting Disorder	
HIV/AIDS		Alzheimer's Disease	
Breast Cancer		Ovarian Cancer	
Uterine Cancer		Colon Cancer	

Cancer (Type)			

Pregnancy History

	Number		Number		Number
Total Times Pregnant		Full Term Deliveries		Caesarean Sections	
Miscarriages		Deliveries before 37 weeks		Forceps	
Abortions		Living Children		Vacuums	

Describe any special pregnancy problems: _____

_____

Social History and Personal Profile

Occupation: _____ Preferred Language: _____Ethnicity: _____
Marital Status: Married Divorced Widowed Significantly Involved Domestic Partner
Education Level: High School College Graduate Degree Other

Exercise: Yes No How Often: _____ Type: _____
Special Diet: Yes No Type: _____
Hobbies, Interests, Goals: _____

Habits

Smoking: Yes No Packs/day: _____ How many years? _____ Ex-Smoker/Quit When: _____
Alcohol: : Yes No Drinks/day: _____ How many years? _____ Quit When: _____
Drug Use: Yes No Type:_____ How many years? _____ Quit When: _____
Caffeine: Yes No Cups/day: _____ Cups/Week: _____
Aspirin: Yes No Dosage: _____
Do you use seatbelts: Yes NO Do you use sunscreen? Yes NO

Personal Safety

Has anyone close to you ever threatened to hurt you?	Yes	No
Has anyone ever hit, kicked, choked, or hurt you physically?	Yes	No
Has anyone, including your partner, ever forced you to have sex?	Yes	No
Are you ever afraid of your partner?	Yes	No

For office staff use only:
Vitals
Height: _____ Weight: _____ Temp: _____ BP: _____

Review of Systems

Please indicate if you have any of the following symptoms TODAY.

		Notes			Notes
Constitutional			**SKIN/BREAST**		
Fever	☐		Breast pain	☐	
Chills	☐		Nipple Discharge	☐	
Fatigue	☐		Breast lumps	☐	
Weight Loss	☐		Rash	☐	
Weight Gain	☐		Ulcers	☐	
Eyes			**Hematologic**		
Changes in vision	☐		Frequent bruising	☐	
Double vision	☐		Cuts do not stop bleeding	☐	
			Enlarged lymph nodes	☐	
ENT/Mouth			**Cardiovascular**		
Ear aches	☐		Chest Pain	☐	
Ringing in the ears	☐		Difficulty Breathing		
Sinus Problems	☐		on exertion	☐	
Sore Throat	☐		Swelling of legs	☐	
Mouth sores	☐		Palpitations	☐	
Dry Mouth	☐		Heart Murmurs	☐	
Respiratory			**Endocrine**		
Wheezing	☐		Abnormal Thirst	☐	
Spitting up blood	☐		Hot flashes	☐	
Shortness of breath	☐		Tremors	☐	
Cough	☐		Cold/Heat Intolerance	☐	
Musculoskelatal			**Psychiatric**		
Muscle Weakness	☐		Depression	☐	
Joint Stiffness	☐		Mood Swings	☐	
Joing Pain	☐		Anxiety	☐	
Joing Swelling	☐		Suicidal thoughts	☐	
			Homicidal thoughts	☐	
Gastrointestinal			**Genitourinary**		
Diarrhea	☐		Blood in urine	☐	
Constipation	☐		Pain with urination	☐	
Nausea/Vomiting	☐		Urgency	☐	
Bloody stool	☐		Urinary Frequency	☐	
Abdominal pain	☐		Urinary Incontinence	☐	
Indigestion	☐		Abnormal bleeding	☐	
Bloating	☐		Vaginal discharge/odor	☐	
Liver Problems/Hepatitis	☐		Vaginal itching/burning	☐	
			Pelvic pain	☐	
			Menstrual cramps	☐	
			Painful intercourse	☐	
			Genital lump	☐	
			Fertility concerns	☐	
			Menopausal concerns	☐	