Panhandle Obstetrics Gynecology

Patient Intake History

Name	**Birth Date /**
Provider you are here to see:	**Barnett Freeman Hopkins May Bergero**
Reason for visit	

Medical History

Asthma	Yes or No	Autoimmune Disease (Lupus, etc)	Yes or No
Heart Disease	Yes or No	Cancer	Yes or No
Diabetes	Yes or No	Depression/Anxiety	Yes or No
High Blood Pressure	Yes or No	Bowel Problems	Yes or No
Stroke	Yes or No	Other	
Sexually Transmitted Infection	Yes or No	Other	
Thyroid Disease	Yes or No	Other	

Surgical History

Procedure	Date	Location

Gynecologic History

First day of last normal menstrual period	/ /
Age periods began	
Length of periods (Number of days of bleeding)	
Number of days between periods	
Are you currently sexually active?	Yes or No
Present Method of Birth Control	
When was your last pap test?	/ /
Have you ever had an abnormal pap test?	Yes or No If yes, when? / /

Obstetric History

Number	Birth Date	Birth Weight	Baby's sex	Weeks Pregnant	Type of Delivery (Vaginal, Cesarean, Etc.)	Complications
1						
2						
3						
4						

Total Number of Pregnancies _____ Total Number of Living Children _____

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Family History

Illness	Yes	Which relative(s) and age of onset
Diabetes		
Heart Disease		
Stroke/Blood clots		
High Blood Pressure		
Breast Cancer		
Ovarian Cancer		
Colon Cancer		
Mental Illness/Depression		
Other		
Other		

Social History

Ever smoked? Current smoking: Packs per day: Years:	Yes or No
Alcohol: Drinks per day: Drinks per week:	Yes or No
Drug Use	Yes or No
Regular Exercise	Yes or No
Marital Status: Married Single Divorced Widowed	
School Completed: High School Some college College Graduate degree Other	
Current or most recent job:	

Current Medications

Drug Name	Dosage	Who prescibed	Reason for medication

Review of Systems

Weight Loss or Weight Gain	Yes or No	Dizziness	Yes or No
Fatigue	Yes or No	Seizures	Yes or No
Chest pain	Yes or No	Depression or frequent crying	Yes or No
Shortness of breath	Yes or No	Anxiety	Yes or No
Diarrhea or Constipation	Yes or No	Hair loss	Yes or No
Heavy periods	Yes or No	Heat/cold intolerance	Yes or No
Irregular periods	Yes or No	Hot flashes	Yes or No
Urine loss when coughing	Yes or No	Latex allergy	Yes or No
Frequent urination or urgency	Yes or No	Medication allergy	Yes or No
Painful intercourse	Yes or No	Please list medication and reaction	
Muscle weakness	Yes or No		
Lumps in breasts	Yes or No		
Nipple discharge	Yes or No		