Vermont Gynecology

INITIAL INTAKE

CONFIDENTIAL

DATE: NAME: DATE OF BIRTH: AGE:

PREFERRED NAME (How should we address you?): YOUR PROFESSION:

WHY ARE YOU HERE TODAY?

Who referred you?

ALLERGIES (to medications or food): ❑ No Known Drug Allergies

YOUR PRIMARY CARE PROVIDER:

❑ Send today's visit note to PCP

OBSTETRIC/GYNECOLOGIC HISTORY

MENSTRUAL HISTORY (Skip if you are postmenopausal or have had a hysterectomy) ❑ N/A

First day of last period: _____ Age when you got your first period: _____
# of days between periods: _____ (i.e. from the *start* of one period to the *start* of the next period)
# of days you bleed: _____ Amount of bleeding? ❑ heavy ❑ medium ❑ light Painful periods? ❑ no ❑ yes
Any problems with period? ❑ no ❑ yes – Explain:

SEXUAL HISTORY

I have sex with: __ male partner(s) __female partner(s) ❑ not active If you have/had intercourse,
__ male and/or female partner(s) __FTM partner(s) __ MTF partner(s) age at first time: _____
I have had, or my partner has had, new partner(s) since last health care visit: ❑ no ❑ yes ❑ not active since then
With sexual activity, do you have: ❑ pain ❑ bleeding Date of last Pap: _____ Where was Pap? _____
Please list any questions/concerns:

PREGNANCY HISTORY ❑ No pregnancies

of full-term pregnancies: # of premature pregnancies: # of vaginal births: ❑ forceps/vacuum?
# of c-sections: # of miscarriages: # of abortions: # of ectopic pregnancies:
# of living children: # of children placed for adoption: # of children adopted:

CONTRACEPTIVE HISTORY ❑ N/A

If you use a birth control method, what is it? Problems with it? ❑ no ❑ yes:
Other methods used in past: Interested in changing methods? ❑ no ❑ yes

MENOPAUSE AND BEYOND ❑ N/A

Age you stopped having periods: _____ Problems or concerns? ❑ no ❑ yes: _____
Taking hormone therapy or other remedies? ❑ no ❑ yes – Please list:

GYNECOLOGIC HISTORY – Check if you have or have had

❑ Abnormal uterine bleeding	❑ Premenstrual syndrome	❑ Vulvar skin problem: _____
❑ Fibroids ❑ Endometrial polyps	❑ Vaginitis (yeast, BV, other)	❑ DES exposed ❑ Genital warts
❑ Endometriosis ❑ Pelvic pain	❑ Pelvic infection/PID	❑ Abnormal Pap smear ❑ HPV
❑ Ovarian cysts or tumors	Herpes: ❑ oral ❑ genital	❑ Colposcopy
❑ Infertility issues	❑ Chlamydia ❑ Gonorrhea ❑"Trich"	❑ LEEP or Cone ❑ Cryotherapy
Loss of: ❑ urine ❑ stool ❑ both	Do you douche? ❑ no ❑ yes	When? _____ Result? _____

Details:

HEALTH AND NUTRITION

I exercise ____ times per week. Types of exercise I do: _____
I eat a well balanced diet ❑ no ❑ yes I eat ____ servings of fruits & vegetables per day (serving = ½ cup)
I take calcium &/or eat calcium-rich foods ❑ no ❑ yes – Amount/sources? _____
I take Vitamin D ❑ no ❑ yes – Amount/sources? _____
I drink alcohol ❑ no ❑ yes – What? How much? How often? _____
I smoke tobacco products ❑ no ❑ yes How many packs/day? _____ ❑ Ex-smoker ❑ Year quit: _____
I use other drugs ❑ no ❑ yes – Which one(s)? _____

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INITIAL INTAKE, continued CONFIDENTIAL

DATE: NAME: DOB: AGE:

MEDICAL AND FAMILY HISTORY

❑ I have no knowledge of my family history

Please note which family member(s) was/were affected for each condition. Use extra space below if needed.

Check if yes:	Self	Family	Check if yes:	Self	Family	Check if yes:	Self	Family
Breast cancer			High cholesterol			Skin problems		
Ovarian cancer			High blood pressure			Jaundice/hepatitis		
Colon cancer			Blood clots lungs/leg			Tuberculosis		
Uterus cancer			Thyroid problems			HIV/AIDS		
Other cancer:			Lung problems			Anemia		
Diabetes			Breast problems			Birth defects		
Heart disease			Colon problems			Varicose veins		
Rheumatic fever			Reflux/Ulcer (circle)			Migraines		
Stroke			Stomach problem			Non-migraine h/a		
Osteoporosis			Gallbladder problem			Seizure/epilepsy		
Bone/hip fracture			Kidney/bladder prob			Depression		
Arthritis/joint pain			Urine infections			Anxiety		
Additional history & details								

SURGERIES, HOSPITALIZATIONS, ACCIDENTS &/OR SERIOUS ILLNESSES

	YEAR:		YEAR:
	YEAR:		YEAR:
	YEAR:		YEAR:

MEDICATIONS, VITAMINS, HERBS AND SUPPLEMENTS (Include doses and frequency if known)

PREVENTION & SCREENING

VACCINATION RECORD

❑ I have had the tetanus vaccine within last 10 years
❑ I have had the HPV vaccines as child, teen or young adult
❑ I have had measles, mumps, and rubella or was vaccinated
❑ I have had chicken pox or was vaccinated
❑ I have had the Hepatitis B vaccinations
❑ If over 60, I have had the shingles vaccine
❑ If over 65, I have had the Pneumovax vaccine
❑ I have had the meningitis vaccine
❑ Other:

DOMESTIC VIOLENCE – As we are concerned about your safety and because it is so common, we ask all our patients about the presence of violence and abuse in their home. Are you being:

❑ Hurt?
❑ Insulted or talked down to?
❑ Screamed or cursed at?
❑ Threatened with physical harm?

❑ I have a history of sexual abuse/battering

Cholesterol test? ❑ no ❑ yes When? _____ Where? _____ Result? _____

Mammogram? ❑ no ❑ yes When? _____ Where? _____ Result? _____

Colonoscopy? ❑ no ❑ yes When? _____ Where? _____ Result? _____

Bone density/DXA? ❑ no ❑ yes When? _____ Where? _____ Result? _____

Other(s): _____ ❑ no ❑ yes When? _____ Where? _____ Result? _____

❑ I have written advanced directives

❑ I would like a written summary of today's visit posted to my patient portal