Vermont Gynecology

INTERVAL INTAKE

CONFIDENTIAL

DATE: NAME: DATE OF BIRTH: AGE:

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

WHY ARE YOU HERE TODAY?

CURRENT MEDICATIONS, HERBS, VITAMINS &/OR SUPPLEMENTS (include frequency and doses, if known):

ALLERGIES (to medications or food) ☐ NKDA

YOUR PRIMARY CARE PROVIDER:

❑ Send today's visit note to PCP

OBSTETRICAL/GYNECOLOGICAL HISTORY

MENSTRUAL HISTORY (skip if you are postmenopausal or have had a hysterectomy)

First day of last period: _____ # of days between periods: _____ (from start of one to start of next menses)
# of days you bleed: _____ Amount of bleeding? ❑ heavy ❑ medium ❑ light ❑ Menses painful
Any problems with period, questions or concerns?:

SEXUAL HISTORY

I have sex with: __male partner(s) __female partner(s) __either/both male &/or female partner(s)
__MTF partner(s) __FTM partner(s) ❑ not active

I have had or my partner(s) has had new partner(s) since last visit: ❑ no ❑ yes ❑ unknown ❑ have not been active
With sexual activity, do you have: ❑ pain ❑ bleeding ❑ I want safer sex information
Please list any questions/concerns:

Date and site of last Pap and/or HPV, if not done here at VTGyn: ❑ done here
❑ Pap/HPV results:

PREGNANCY HISTORY

Pregnant since last visit? ❑ no ❑ yes If yes, please note date(s) and outcome(s) of pregnancy(ies):

CONTRACEPTIVE HISTORY ❑ N/A

If you use a birth control method(s), what do you use? _____
Questions/problems with method? ❑ no ❑ yes Interested in changing birth control methods? ❑ no ❑ yes
Please list questions/problems:

MENOPAUSE AND BEYOND ❑ N/A

Age you stopped having periods: _____ Problems/concerns? ❑ no ❑ yes – Please describe:

Taking hormone therapy or other remedies? ❑ no ❑ yes If so, what are you taking? (List herbs, meds, etc. below.)

MEDICAL HISTORY

Since last visit here, any changes in gynecologic, medical and/or family history? ❑ no ❑ yes
Please list:

Since last visit here, any hospitalizations, surgeries, accidents or serious illness? ❑ no ❑ yes
Please list:

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INTERVAL INTAKE, continued **CONFIDENTIAL**

NAME: DATE OF BIRTH: TODAY'S DATE:

REVIEW OF SYSTEMS

Do you have any current problems with (check all that apply and explain in spaces provided): ❑ No current problems

❑ General wellness	
❑ Skin	
❑ Head/Eyes/Ears/Nose/Throat	
❑ Breasts	
❑ Heart	
❑ Lungs	
❑ Bladder	
❑ Bowel	
❑ Muscles/Joints	
❑ Neurologic symptoms	
❑ Psychiatric symptoms	
❑ Endocrine (e.g. thyroid)	
❑ Other	

HEALTH, NUTRITION, PREVENTION

I exercise ____ per week. Types of exercise I do:

I eat a well balanced diet: ❑ no ❑ yes I eat _____ servings of fruits and vegetables per day (serving = ½ cup).
Specific diet? Please describe: _____
I take calcium &/or consume calcium rich foods ❑ no ❑ yes What sources and how much? _____
I take Vitamin D or get it from food ❑ no ❑ yes How much and how often? _____

I drink alcohol ❑ no ❑ yes What kind, how much, and how often? _____
I smoke tobacco products ❑ no ❑ yes How much and how often? _____ ❑ Ex-smoker (Quit:_____)
I use other drugs ❑ no ❑ yes Which one(s) and how often? _____

Since last visit have you had:

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 am concerned about my safety in my relationship: ❑ no ❑ yes

I have written advanced directives: ❑ no ❑ yes

VACCINATION RECORD

□ I have had the tetanus vaccine within the last 10 years
□ I have had measles, mumps, and rubella or was vaccinated
□ I have had the HPV vaccine series as a child, teen or young adult
□ I have had chicken pox or was vaccinated
□ I have had meningitis vaccine
□ I have had hepatitis B vaccinations
□ If over 60, I have had the shingles vaccine
□ If over 65, I have had Pneumovax vaccine

□ I would like a written summary of today's visit