INTERVAL INTAKE

CONFIDENTIAL

DATE: **NAME:** **DATE OF BIRTH:** **AGE:**

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

PREFERRED PRONOUNS (circle): She/Her He/Him They/Them Other (specify):

WHY ARE YOU HERE TODAY?

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

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

YOUR PRIMARY CARE PROVIDER:

OBSTETRICAL/GYNECOLOGICAL HISTORY

MENSTRUAL HISTORY (***skip if N/A, e.g. 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? (Describe)

SEXUAL HISTORY

I have sex with (mark all applicable): __ Male partner(s) __ Female partner(s) __ Nonbinary partner(s)
__ FTM partner(s) __ MTF partner(s) __ Self ❑ 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:

Vermont Gynecology **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 50, I have had the shingles vaccine
□ If over 65, I have had Pneumovax vaccine