Coastal Women's Wellness

PATIENT INTAKE HISTORY

Date _____

Name _____

Date of Birth _____

Primary Care Provider _____

How did you hear about us?_____

What is the purpose of your visit today?_____

_____

GYNECOLOGY HISTORY

First day of last period _____

Have you been sexually active in past 6 months? _____

Method of Contraception _____

Date of last pap smear _____ Result _____

Date of last mammogram _____ Result _____

Date of last bone density test _____ Result _____

Date of last colonoscopy _____ Result _____

CURRENT MEDICATIONS

Drug Name _____ Dosage _____

Drug Name _____ Dosage _____

Drug Name _____ Dosage _____

Drug Name _____ Dosage _____

Drug Name _____ Dosage _____

OBSTETRICAL HISTORY

of Pregnancies _____ Abortions _____ Miscarriages _____ Live Births_____ Living Children _____

MEDICATION ALLERGIES: _____

_____

_____

SURGICAL HISTORY

Procedure _____ Date _____

Procedure _____ Date _____

Procedure _____ Date _____

Procedure _____ Date _____

Procedure _____ Date _____

SOCIAL HISTORY

Do you smoke? **YES NO**

If yes: how many packs per day? _____ How many years have you smoked? _____

Do you use alcohol? **YES NO**

If yes: # drinks per day _____, # drinks per week _____

Do you exercise regularly? **YES NO**

If yes: how many days per week? _____

Have you been sexually abused, threatened, or hurt by anyone? **YES NO**

PERSONAL MEDICAL HISTORY (circle all that apply to you)

STDs	Eating Disorder
Heart Disease/ Stroke	Depression/Anxiety
Blood clot	Seizures
Thyroid Disease	Cancer
Diabetes	High Blood Pressure
HIV/AIDS	Anemia

FAMILY HISTORY

*Please note if any first degree relatives (your mother, father, siblings, or children) have suffered from the following:

Disease	**Which Relative**
Abdominal Aortic Aneurism	_____
Dementia	_____
Mental Illness	_____
Diabetes	_____
Coronary Artery Disease	_____
Hyperlipidemia (high cholesterol)	_____
Hypertension (high blood pressure)	_____
Thromboembolism (blood clots)	_____
Colon Cancer	_____
Prostate Cancer	_____
Breast Cancer	_____
Ovarian Cancer	_____
Lung Cancer	_____
Melanoma (Skin Cancer)	_____
Other	_____
Unknown Family History	_____