## **Female Initial Visit Intake Form** PATIENT INFORMATION Today's Date\_\_\_\_\_ Last Name \_\_\_\_\_\_Mid Initial \_\_\_\_ First Name\_\_\_\_\_ Date of Birth\_\_\_\_\_\_Social Security Number\_\_\_\_\_ Address Street Address Citv State Zip Code Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ E-mail Address\_\_\_\_\_ How did you find us? \_\_\_\_\_ **EMERGENCY CONTACT NAME AND INFORMATION** Name of person to contact in case of an emergency\_\_\_\_\_ Contact's home phone \_\_\_\_\_\_Contact's cell phone \_\_\_\_\_ Contact's relationship to you\_\_\_\_\_ What is the reason for your visit today? \_\_\_\_\_ Where have you been receiving your medical care? Name of Physician \_\_\_\_\_ Street Address State Zip Code PAST MEDICAL HISTORY: Please circle Yes or No for any illnesses that you have had:

Anemia	YES	NO	Hepatitis	YES	NO
Arthritis	YES	NO	High Blood Pressure	YES	NO
Asthma/ Bronchitis/ Emphysema	YES	NO	Immune Disorders	YES	NO
Bleeding/ Bruising	YES	NO	Intestinal Problems	YES	NO
Blood Disorder	YES	NO	Kidney Disease	YES	NO
Cancer (Type)	YES	NO	Liver Disease	YES	NO
Depression/ Emotional Problems	YES	NO	Lung Disease	YES	NO
Diabetes	YES	NO	Skin Disease	YES	NO
Drug/ Alcohol Dependency	YES	NO	Stroke	YES	NO
Epilepsy/ Seizures	YES	NO	Stomach Ulcers	YES	NO
Hay Fever/ Sinus Problems	YES	NO	Thyroid Disease	YES	NO
Heart Problems	YES	NO	Other (Please describe)	YES	NO

Hay Fever/ Sinus Problems	YES	NO	Thyroid Disease	YES	NO			
Heart Problems	YES	NO	Other (Please describe)	YES	NO			
Have you ever been hospitalized? Yes No If yes, please list the date(s) and reason(s):  Have you had any surgeries? Yes No If yes, please list the date(s) and type(s) of surgery:								

Please list any medications y minerals, and herbs:	ou take, including presc	ription drugs,	over-the-counter drugs, eye drops, vitamins,
Name of Medication	Dose or Streng	gth_	How often do you take it?
Have you ever had an allergi	c reaction to a medication	on? 🗆 Yes 🗆 N	No If yes, which medication(s)?
Medication			Reaction
Have you ever had an allergi		following?	
Latex Yes No	o lodine Yes	s No	Other allergies:
Insect stings Yes No	FoodYes	No	(If yes,describe)
FAMILY HISTORY: Have an any of the following?	y members of your fami	ly, (including	grandparents, parents, siblings, and children)

ad any of the following?

Problem	Circle \	Yes or No	Family Relationship
Alcoholism / Substance Abuse	Yes	No	
ALS (Lou Gehrig's Disease)	Yes	No	
Alzheimer's / Dementia	Yes	No	
Anemia / Bleeding Problems	Yes	No	
Asthma/Hay Fever	Yes	No	
Cancer (Breast, Ovarian, Colon, Other)	Yes	No	
Depression / Other Mental Illness	Yes	No	
Diabetes	Yes	No	
Heart Disease / Angina	Yes	No	
Hepatitis / Liver Disease	Yes	No	
High Blood Pressure	Yes	No	
High Cholesterol	Yes	No	
Kidney Disease/ Stones	Yes	No	
Osteoporosis	Yes	No	
Seizure Disorders	Yes	No	
Stroke	Yes	No	
Thyroid Disease	Yes	No	
Tuberculosis	Yes	No	
Other (please describe):	Yes	No	

<b>SOCIAL HISTORY:</b> Please tell us about your lifestyle any of these questions.	e and personal habits. It is OK if you choo	se not to a	nswer
What is your occupation?	Are your retired?	□ Yes □ N	o
Do you live alone? ☐ Yes ☐ No If no, who	o do you live with?		_
Do you follow any special diet? $\square$ Yes $\square$ No	If yes, describe		_
Do you have concerns about your nutrition? $\square$ Yes $\square$	No If yes, describe		_
Do you exercise regularly? □Yes □ No	If yes, describe		_
Do you use chewing tobacco or snuff? □Yes □ No	Do you smoke cigars or cigarettes?		)
If the answer is <b>Yes</b> , answer the questions below:	If the answer is <b>No</b> , answer the question		
For how many years have you smoked?	Have you smoked in the past? Yes _		
How many packs per day do you smoke?	How many packs per day did you smoke	<del>)</del> ?	
Are you interested in quitting?	When did you quit?		
Do you drink alcohol? □ Yes □ No  During the last week, on how many days have you ha	If yes, please answer the questions in the	e box:	
On days when you had a drink, how many drinks (be			
Have you ever felt that you ought to cut down on you	ır drinking?	Yes	No
Have people criticized your drinking?		Yes	No
Have you ever felt bad or guilty about your drinking?		Yes	No
Have you ever had to have a drink first thing in the m	norning		
to steady your nerves or get rid of a hangover?		Yes	No
Have you ever had blackouts or memory loss?		Yes	No
Do you use or take any drugs such as marijuana, cool if yes, describeHave you had sex with men?   Yes  No Do you and your sexual partner(s) practice safe sex?	Have you ever injected any drugs? Ye have you had sex with women? Ye have you had sex with women?	res No res No	0
Risk factors for infection with HIV, the AIDS virus, indintravenous drug use, hemophilia, past history of a behilv-positive individual or other person with these risk being tested for HIV infection, please discuss this with	lood transfusion between 1979-1985, and k factors. If you have any of these risk fact	sexual coi	ntact with an
In the last 12 months, have you been hurt or felt three During the past month, have you felt "down" or depre Do you have trouble finding pleasure in things you us Have you ever been so sad that you thought about h	essed?` sed to enjoy?``	Yes No Yes No Yes No Yes No	0 0

## PREVENTIVE CARE:

Have you received a vaccine to prevent any of the following diseases? If yes, please list date.							
Tetanus (DT) No Yes Date:							
Influenza (flu) No Yes Date:							
Pneumonia	No	Yes	Date:				
Hepatitis B No Yes Date:							
Rubella / MMR	No	Yes	Date:				

Have you ever had any of these screening tests done? If yes, please give date of last test.								
			Γ=					
Cholesterol	No	Yes	Date:					
Tuberculin skin	No	Yes	Date:					
test								
Stool test for	No	Yes	Date:					
blood								
Sigmoidoscopy	No	Yes	Date:					
or								
colonoscopy								
Mammogram	No	Yes	Date:					

PAIN & FUNCTIONAL STATUS: As health care p	providers, we are concerned about your comfort.
Do you suffer from pain? □ Yes □ No	If yes, answer the questions in the box below:

Where is your pain?	What does your pain feel like?												
Circle a number from 1-	10 th	at bes	t descr	ibes h	now m	uch pa	ain you	ı are h	aving	now:			
	1	2	3	4	5	6	7	8	9	10			
What makes the pain I	bette	r?									 		
What makes the pain	worse	e?									 	<del></del>	
Does the pain limit your activity or interfere with your sleep? If yes, please describe:													
Please list any medication(s) or other type(s) of treatment you use for pain relief:													

Are you receiving any special help at home?  $\square$  Yes  $\square$  No

## **REVIEW OF SYSTEMS:**

Have you experienced any of the	Yes	No	Patient Comments	Provider Comments
following in the past 3-6 months?				
change in general health				
recent weight changes				
recurrent fevers, chills, or sweats				
heat or cold intolerance				
extreme fatigue				
change in appetite				
excess thirst or urination				
difficulty sleeping				
nervousness / anxiety				
difficulty sleeping				
depression				
delusions / hallucinations				
easy bruising				
frequent or prolonged bleeding				
enlarged lymph nodes				
decreased resistance to infection				
unusual rash / skin problems				
delayed healing				
change in hair or nails				
headaches				
numbness / tingling sensation				
weakness / paralysis				
convulsions / seizures				
confusion / change in memory or				
concentration				
black outs / dizziness				
change in hearing / ringing in ears				
recent nose bleeds				
chronic sinus problems / runny nose				
allergy symptoms				
voice changes				
recurrent sore throat				
difficulty swallowing				
wear glasses or contact lenses				
change in vision				
pain or irritation in eye(s)				
redness or discharge from eye(s)				
breathing problems / shortness of		-		
breath				
chronic cough				
coughing-up blood				
chest pain or angina		-		
irregular heart rhythm / palpitations				
swelling of feet, ankles, hands				
breast pain		-		
breast lump or swelling				
severe heartburn				
nausea or vomiting				
vomiting blood				
abdominal pain				
constipation				
frequent diarrhea				
black or bloody stools				
joint / muscle stiffness, pain,		1		
weakness				
neck pain / back pain				
difficulty walking				
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## FOR WOMEN ONLY:

Have you ever had a mammogram? (If yes, please give date and results of last mammogram and where mammogram was done)  Have you ever had an abnormal mammogram? (If yes, please give date, results, and treatment)  Date: Results:  (If yes, please give date, results, and treatment)  Do you routhely practice self-breast exams?   Have you ever had:  Have you ever had an abnormal PAP smear?   Have you ever had an abnormal PAP smear?   Date:  Results:  Results:  Treatment:   Do you have problems with any of the following:  urinary frequency / urgency  frequent urination at night  lack of bladder control / incontinence  painful urinarion  blood in urine  recurrent urinary tract infections  vaginal discharge  vaginal pain / riching / irritation  blood in urine  recurrent urinary tract infections  vaginal discharge  vaginal pain / riching / irritation  blood where you when you had your  first menstrual periods?  Do you still have menstrual periods?  How old were you when you had your  first menstrual periods?  How woull wou describe your  periods?  How many days are there between  periods?  How would you describe your  periods?  Heavy our ever been pregnant?  (If yes, please fill-in total number of  pregnancies; deliveries,  miscarriages, and abortions)  Do you currentity use any form of  birth control used:  birth Control used:	Please answer the following questions:	Yes	No	Patient Comments	Provider Comments
Id yes, please give date and results of last mammogram was done)  Have you ever had an abnormal mammogram (if yes, please give date, results, and treatment)  Do you routinely transmitted disease gental or anal warts  Where you ever had: sexually transmitted disease gental or anal warts  When was your last PAP smear?  Have you ever had an abnormal PAP smear? Results:  Date: Results:  Treatment:  Do you have problems with any of the following uninary frequency / urgency frequent unination at night lack of bladder control / incontinence painful unination blood in urine recurrent uninary tract infections vaginal discharge vaginal pain / tiching / irritation vaginal discharge  How old were you when you had your first menstrual periods? If you are still having periods, on what day did your last periods start?  How many days are there between periods?  How long does you period last?  How out goes you period last?  How would you describe your periods?  How many days are there between periods?  How only goes you period last?  How would you describe your periods?  How would you describe your periods?  How would you describe your periods?  How only does you period last?  How would you describe your periods?  How would you describe your periods?  How would you describe your periods?  How you ever been on hormone replacement therapy?  How you ever been on hormone replacement therapy?  How control you were been pregnant?  (If yes, please fill-in total number of pregnancies, deliveries, miscarriages, and abortions)  Do you urrentify use any form of birth control?		. 55	1.10		1 TOTIGOT SOMMIONO
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vaginal pain / itching / irritation       vaginal dryness       hot flashes       change in sex drive       bleeding between periods / after       menopause       How old were you when you had your       first menstrual periods?       If you are still having periods, on what       day did your last period start?       Are your periods regular?       How many days are there between periods?       How long does your period last?       How would you describe your periods?       Heavy       Moderate       Light       Are your periods painful?       Have you ever been on hormone replacement therapy?       Have you ever been pregnant?     # of pregnancies:       (If yes, please fill-in total number of pregnancies, deliveries, miscarriages, and abortions)     # of abortions:       Did you have complications with a pregnancy?     Complications:       (If yes, please describe)     Birth Control used:					
vaginal dryness       hot flashes         change in sex drive       bleeding between periods / after menopause         How old were you when you had your first menstrual periods?       Age:         If you are still having periods, on what day did your last period start?       Date:         Are your periods regular?       Days:         How many days are there between periods?       Days:         How long does your period last?       Days:         How would you describe your periods?       Heavy         Moderate       Light         Are your periods painful?       Dates:         Have you ever been on hormone replacement therapy?       Types:         Have you ever been pregnant?       # of pregnancies:         (If yes, please fill-in total number of pregnancies, deliveries, miscarriages, and abortions)       # of deliveries:         Did you have complications with a pregnancy?       Complications:         (If yes, please describe)       Birth Control used:					
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