New Patient Intake History

Patient Name:___________________________ Date: _______________________

Reason for Visit:____

We appreciate you taking the time to fill out your history information. This information will be kept confidential and will be used to guide us in your health care. Thank you in advance for letting Elite Ob/Gyn service your health care needs.

Date of last Pap smear ___________________ results ______________________

Any abnormal pap smears? ☐YES ☐NO if yes, when ___________ and what type of follow up____________________________________

Date of last Mammogram ________________ results __________________________

Date of last Bone Density ____________________ results _______________

Date of last colonoscopy ____________________ results ________________

Date of last Gardasil injection/HPV Vaccination (if applicable) _____________.

I have had (circle one) 0 of 3 1 of 3 2 of 3 3 of 3 injections

General Medical History:

Please list any major medical conditions for which you have been diagnosed:

_________________________________ ___________________________________

_________________________________ ___________________________________

_________________________________ ___________________________________

Surgical History:

Date	Operation

Medications: (please include all hormones, vitamins, herbs, and nonprescription medications)

Drug Name	Dose

Allergies:

Drug/allergen name	Reaction

Family History:

Family member (relation)	**Medical conditions**	**Living/ deceased**
mother		
father		
brothers		
sisters		
Other:		

Gynecologic History:

First day of your last menstrual period ____/_____/______

How often do you have periods? (i.e. every 28 days) _________ Are they regular ☐Yes ☐ NO

explain:____

Approximate number of bleeding days during your period _________.

With your cycle, do you experience: □ Cramps □Heavy Bleeding □Mood Swings □Spotting

Present method of birth control: □ condoms □ withdrawal □ rhythm method

□ birth control pills □ nNuvaRing □ patch □ Mirena IUD

□ Paragard IUD □ tubal ligation □ vasectomy □ none

Are you happy with this method □ YES □ NO □ would like to discuss.

If menopausal, have you ever used hormone replacement therapy? __________________

If, yes, are you still on therapy? ________________________________

Have you ever had a sexually transmitted disease? ☐YES ☐ NO what types?_____________

Pregnancy History:

_______ Total # Pregnancies | _______ # Full term | _______ # Preterm | _______ # elective abortions | _______ # miscarriages | _______ # ectopics | _______ # multiples | _______ # living

Birth Date Mo/day/yr	# weeks	Birth weight	Sex M/F	Type of delivery	Preterm labor?	Complications?	location

Social History:

Relationship Status: ☐Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

☐ sexually active ☐ not currently active ☐ never active

☐ heterosexual ☐ homosexual ☐ bisexual

Current or most recent job/occupation:____

Tobacco Use: ☐ Never used tobacco

☐ Current use: packs/day _____ Year Started ______

☐ Past use: packs/day ______Year started ______ Year ended ______

Ilicit Drug Use: ☐ NO ☐ Yes if yes: type:_______________

☐ Past History of use: ____________

Alcohol Consumption: ☐ beer ☐wine ☐liquor: drinks/week ____ or drinks/Month___

Exercise: ☐ No ☐ Yes Sessions/week _____