ADVANCED WOMEN'S HEALTH SPECIALISTS
INTAKE FORM

GENERAL INFORMATION:

Your Name: _____ Age: _____

Today's Date: _____ Date of Birth: _____

Referring Physician: _____ (if any)

DO YOU CURRENTLY HAVE A PROBLEM WITH:

Are you having any new problems with onset of a breast mass, skin changes in the breast, or unusual breast discharge which may have developed since your last routine exam?

☐ Yes ☐ No

Are you having any new problems with abdominal or pelvic pain which has developed since your last visit and for which no diagnosis has been made by another health care provider?

☐ Yes ☐ No

Have you had a problem with new onset of abnormal bleeding?

☐ Yes ☐ No

Frequent Urination

☐ Yes ☐ No

Vaginal Discharge

☐ Yes ☐ No

Sexual Function

☐ Yes ☐ No

REASON FOR TODAY'S VISIT: _____

MENSTRUAL HISTORY:

Age at first period _____ Date of last period _____

If you are post-menopausal skip the rest of this section.

Periods occur every _____ days.

Periods last _____ days from start to stop.

PAST MEDICAL HISTORY:

HAVE YOU HAD/DO YOU HAVE (CIRCLE)?

Heart Disease	Lung Disease
Kidney or Bladder Disease	Ear, Nose, Throat, Mouth Disease
Hepatitis or Liver Disease	Neurological or Seizure Disorder
Skin Disease	Diabetes or Thyroid Disease
Bone, Muscle or Orthopedic Disease	Blood Clot in Lung or Leg
Blood or Lymphatic Disease	Immune or Allergic Disorders
Psychiatric or Psychological Problem	Intestinal or Digestive Disease
Breast Disease	High Blood Pressure
Mitral Valve Prolapse	High Cholesterol
Abnormal Pap	Cancer
Venereal Disease	

OTHER SERIOUS ILLNESS: _____

_____

_____

SURGICAL HISTORY/HOSPITALIZATION:

PRACTITIONES COMMENTS: _____

_____

_____

PLEASE LIST ALL ALLERGIES/MEDICATION ALLERGIES ALSO:

_____

_____

_____

PLEASE LIST CURRENT MEDICATIONS:

_____

_____

THE FOLLOWING QUESTIONS ARE ASKED TO ONLY HELP US OPTIMIZE YOUR MEDICAL CARE:

Do you work outside the house?

☐ Yes ☐ No

Occupation _____

Do you Smoke?

☐ Yes ☐ No

How many packs a day? _____

Do you use any recreational drugs?

☐ Yes ☐ No

Married

☐ Yes ☐ No

Ethnicity/Race _____

Drink Alcohol?

☐ Yes ☐ No

How much Alcohol? _____

Please list drugs used _____

_____

Number of sexual partners in lifetime _____ In last year _____

PREGNANCIES:

How many times have you been pregnant? _____

How many pregnancies miscarried? _____

How many abortions? _____

How many vaginal deliveries? _____

How many cesarean sections? _____

How many tubal pregnancies? _____

How many molar pregnancies? _____

How many living children? _____

Age of last pregnancy? _____

CURRENT METHOD OF BIRTH CONTROL:

☐ None	☐ Withdrawal
☐ Birth Control Pills	☐ Patch
☐ Shot	☐ Condoms
☐ IUD	☐ NuvaRing
☐ Tubal Ligation	☐ Vasectomy
	☐ Other

FAMILY MEDICAL HISTORY:

If you are adopted (circle) and don't know your family medical history please skip to the next section.

Is your mother living?

☐ Yes ☐ No

Her current age or her age at death: _____

Is your father living?

☐ Yes ☐ No

His current age or his age at death: _____

Number of Sisters: _____ Number of Brothers: _____

PARENT, CHILD, SISTER, BROTHER, AUNT, UNCLE, OR GRANDPARENT WHO IS BLOOD RELATIVE:

CONDITIONS	Y	N	RELATIVE/AGE AT DIAGNOSIS
OVARIAN CANCER	☐	☐	
BREAST CANCER	☐	☐	
UTERINE CANCER	☐	☐	
COLON CANCER	☐	☐	
HEART DISEASE	☐	☐	
DIABETES	☐	☐	
HIGH BLOOD PRESSURE	☐	☐	
STROKE	☐	☐	
GENETIC DISEASE	☐	☐	

HAVE YOU HAD (CIRCLE)?

Uterus removed (Hysterectomy) (Vaginal or Abdominal)	Breast Biopsy
One or both ovaries removed	Mastectomy
One or both tubes removed	Tubes tied
Appendix removed	Tonsils removed
Gall Bladder removed	Thyroid Surgery
Benign or cancerous (circle) breast lump removed	Laparoscopy
freezing, Leep or cone biopsy for abnormal pap	C-Section

HAVE YOU HAD OTHER SURGERIES (INCLUDING OUTPATIENT) OR BEEN HOSPITALIZED OVERNIGHT?

_____

_____

_____

_____

_____