

DR. PAUL MORRISON'S OBSTETRIC AND GYNECOLOGIC INTAKE HISTORY

NAME: _____ BIRTH DATE: ___/___/___ DATE: ___/___/___

ADDRESS: _____

CITY _____ STATE/ZIP: _____

HOME TEL:() _____ WORK TEL:() _____

EMPLOYER: _____ INSURANCE: _____

NAME OF SPOUSE/PARTNER: _____ REFERRED BY: _____

Did your doctor send you to us? Yes No

WHAT BRINGS YOU TO OUR OFFICE? I AM PREGNANT I WANT TO BE PREGNANT
 ANNUAL EXAM/YEARLY BIRTH CONTROL/TUBAL PELVIC PAIN BLEEDING PROBLEMS
 LOOSING URINE/TROUBLE WITH URINATION MENOPAUSE
 OTHER _____

REVIEW OF SYSTEMS:

DO YOU EVER LEAK URINE OR HAVE TO WEAR A LINER/PAD BECAUSE OF URINE? YES NO

DO YOU HAVE HOT FLASHES/NIGHT SWEATS? YES NO

PERSONAL PAST HISTORY

Do you or have you had any of these major illnesses	Yes	No	Do you or have you had any of these major illnesses	Yes	No
Asthma			Cancer		
Pneumonia			Ulcers		
Chronic Lung Disease			Depression/anxiety		
Kidney 0 Infections 0 stones			Anemia		
Seizures/convulsions/epilepsy			Blood transfusions		
Blood Clots in leg or lung (DVT/PE)			Bowel trouble		
Heart Trouble/murmur			Glaucoma		
Diabetes			Arthritis/joint pain		
High Blood Pressure			Fracture		
Stroke			Hepatitis/Yellow jaundice		
Rheumatic Fever			Thyroid Disease (0 Hypothyroid 0 Hyperthyroid)		
Other? Please list:					

OPERATIONS/SURGERIES

Type of Surgery	Reason	Date	Other types of Surgery	Reason	Date
Hysterectomy? <input type="radio"/> Yes <input type="radio"/> No					
Tubal? <input type="radio"/> Yes <input type="radio"/> No					
C-Section? <input type="radio"/> Yes <input type="radio"/> No					

HOSPITALIZATIONS/INJURIES/ILLNESSES

Type/Reason	Date	Type/Reason	Date

OB/GYN HISTORY			
Number of: Vaginal Births () C-Sections ()		Number of: Term Births ()	
Miscarriages () Tubal Pregnancies () Abortions ()		Preterm Births () Multiples [twins, triplets] () Living Children ()	
Have you had an abnormal Pap Smear? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> LEEP (year) <input type="radio"/> Cold Knife Cone (year) <input type="radio"/> Cryo or freezing of cervix (year)		Have you ever had: <input type="radio"/> none of these <input type="radio"/> Gonorrhea <input type="radio"/> Chlamydia <input type="radio"/> Syphilis <input type="radio"/> Herpes <input type="radio"/> Trichomonas <input type="radio"/> HIV <input type="radio"/> PID/Pelvic Inflammatory Disease <input type="radio"/> HPV <input type="radio"/> Genital Warts	
CURRENT MEDICATIONS			
Drug Name/Dose/Times a day (if more than 4, please attach list and mark here 0 Med list attached)			

DO YOU TAKE VITAMINS OR SUPPLEMENTS? YES NO IF YES, WHICH TYPE? _____

FAMILY HISTORY

Illness	Y/N	Relative	Illness	Y/N	Relative
Diabetes			Uterine Cancer		
Stroke			Breast Cancer		
Heart Disease			Colon Cancer		
High Blood Pressure			Ovarian Cancer		
Problems with Anesthesia					

OTHER FAMILY HISTORY? _____

SOCIAL HISTORY

Have you or do you Smoke?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Packs per day _____	For _____ years
Have you quit smoking	Yes <input type="checkbox"/>	No <input type="checkbox"/>	When did you last smoke?	(month/year) _____
Do you drink Alcohol	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Drinks per day _____	Per week ___ Per Month ___
Are you an Alcoholic	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes, date of your last drink?	(month/year) _____
Drug Use	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Type(s) _____	
Are you in recovery	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes, since when?	(month/year) _____
Personal Profile				
Marital Status	Married <input type="checkbox"/>	Single <input type="checkbox"/>	Widowed <input type="checkbox"/>	Divorced <input type="checkbox"/>
Number of Living Children	_____			
Number of people in household	_____			
School Completed	High School <input type="checkbox"/>	College <input type="checkbox"/>	Graduate Degree <input type="checkbox"/>	Other <input type="checkbox"/>
Current or most recent job	_____			

Do you ever feel like you are in danger in your home? Yes No

Completed by: Patient Office Nurse Parent Physician Other _____

Printed name of patient: _____

Signature of patient: _____ Date _____

Physician Signature: _____ Date _____

Annual Review of History

Date reviewed: _____ Patient Initials _____ Physician Signature: _____

Date reviewed: _____ Patient Initials _____ Physician Signature: _____

Date reviewed: _____ Patient Initials _____ Physician Signature: _____

Date reviewed: _____ Patient Initials _____ Physician Signature: _____