Developed by the Female Force Readiness Navy Medicine Operational Clinical Community

Gynecology Patient Intake Tool

DATE: ____________________

REASON FOR VISIT: ____________________

ARE YOU SIGNED UP FOR THE PATIENT PORTAL? *(please circle yes or no)* **YES / NO**

WHAT IS YOUR PREFERRED METHOD OF COMMUNICATION? *(please write a phone number or email address)* ____________________

MEDICAL AND SURGICAL HISTORY

MEDICAL HISTORY

Have you ever had any of the following?
(please circle yes or no)

- Cancer? **YES / NO**
- Diabetes? **YES / NO**
- High Blood Pressure? **YES / NO**
- Blood clots in your legs or lungs? **YES / NO**
- Stroke or Heart Attack? **YES / NO**
- Depression or Anxiety? **YES / NO**
- Posttraumatic Stress Disorder? **YES / NO**
- Bipolar Disorder? **YES / NO**
- Liver Disease? **YES / NO**
- Sleep Apnea? **YES / NO**
- High or Low Thyroid Function? **YES / NO**
- High Cholesterol? **YES / NO**
- Migraines? **YES / NO**
- Asthma? **YES / NO**

SURGICAL HISTORY

Please check the box for any surgeries you have had and list the year they were performed.

- ❑ Hysterectomy ____________________
- ❑ Tubal Ligation ____________________
- ❑ Bladder Surgery ____________________
- ❑ Cesarean Section (C-Section) ____________________
- ❑ Appendectomy ____________________
- ❑ Gallbladder Surgery ____________________
- ❑ Surgery of the Breast ____________________
- ❑ Tonsillectomy ____________________
- ❑ Dilation and Curettage (D&C) of the Cervix ____________________

Please list any other medical conditions or surgical procedures: ____________________

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SOCIAL HISTORY

Tobacco Use:
Cigarette Use: **YES / NO** Prior Use: **YES / NO**
If yes, total years smoking? ____________
Stopped age? __________ Other tobacco use? ___________

E-Cigarette / Vaping Use:
Do you use e-cigarettes or vaping devices? **YES / NO**
Type? (circle all that apply)
Cannabinoid / Flavored / Nicotine Infused

Alcohol Use:
Do you drink alcohol? **YES / NO**
How many drinks per week? ____________
Type of drink? (circle all that apply) **Beer / Wine / Liquor**

Sexual Preference (circle one):
Heterosexual / Homosexual / Bisexual / Queer / Other

Home Environment:
Who do you live with? ____________________
Marital Status: (circle one) **Married / Single / Divorced / Legally Separated / Widowed**

FAMILY HISTORY

Please list family members diagnosed with conditions listed below, their relationship to you, and their age at diagnosis.

- Breast Cancer ____________________
- Ovarian Cancer ____________________
- Colon Cancer ____________________
- Uterine Cancer ____________________
- Bleeding or Clotting Disorder ____________________
- Please list any other family history of medical conditions: ____________________

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GYNECOLOGIC HISTORY

Menstrual History:

Age at first period:___________

First day of your last period:__________

Interval between periods: every _____ days

Duration of periods: _____days

Please circle one:

Is your flow: **HEAVY / MEDIUM / LIGHT**

Do you have pain during your period? **YES / NO**

Do you bleed between periods? **YES / NO**

Pap Test History:

Have you ever had? *(please circle yes or no)*

- An abnormal pap test? **YES / NO**
  - If yes, when? _________
- A colposcopy? **YES / NO**
  - If yes, when? _________
- A cold knife cone procedure or LEEP? **YES / NO**
  - If yes, when? _________

Last pap test and the results: _________________

SEXUAL HISTORY

Please circle yes or no:

Have you had more than 2 sexual partners in the last year? **YES / NO**

Do you have pains or concerns with sex? **YES / NO**

Please check all that apply:

History of Sexually Transmitted Infections:

❑ Gonorrhea ❑ Syphilis
❑ Genital Warts ❑ Vaginal Herpes
❑ Chlamydia ❑ HIV

Current Contraceptive Used:

❑ Tubal Ligation
❑ Vasectomy
❑ Nexplanon
❑ Depo Provera
❑ IUD
❑ Birth Control Pills
❑ Condoms
❑ Other: ___________________________________

PREGNANCY HISTORY

How many times have you been pregnant? ________

Of those pregnancies, please fill in the following details:

Miscarriages: ______ / **Abortions**: _______ / **Living Children**: ______

Year of Pregnancy	Sex of Child	Weight of Child	Delivery *(vaginal, cesarean, etc.)*	Complications

REVIEW OF HEALTH SYSTEMS

Do you currently have any of the following? Please check all that apply.

❑ Tired Easily
❑ Fevers
❑ Chills
❑ Weight Changes
❑ Appetite Changes
❑ Headache
❑ Visual Changes
❑ Heat/Cold Intolerance
❑ Hot Flashes
❑ Night Sweats
❑ Insomnia
❑ Anxiety
❑ Depression
❑ Mood Swings
❑ Nipple Discharge
❑ Breast Pain
❑ Chest Pain
❑ Palpitations
❑ Shortness of Breath
❑ Nausea
❑ Vomiting
❑ Constipation
❑ Diarrhea
❑ Bowel Frequency Changes
❑ Abdominal Pain
❑ Frequent Urination
❑ Pain with Urination
❑ Abnormal Vaginal Discharge
❑ Blood in Urine
❑ Urine Leakage
❑ Vaginal Itching
❑ Vaginal Odor
❑ Pelvic Pain

DEPRESSION AND ANXIETY HISTORY

Over the past two weeks, how often have you been bothered by any of the following? *(Please check one)*

Depression:

Little interest / pleasure in doing things: ❑ Not at all ❑ Several days ❑ More than half the days ❑ Nearly every day

Feeling down, depressed, or hopeless: ❑ Not at all ❑ Several days ❑ More than half the days ❑ Nearly every day

Anxiety:

Feeling nervous, anxious, or on edge: ❑ Not at all ❑ Several days ❑ More than half the days ❑ Nearly every day

Not being able to stop / control worrying: ❑ Not at all ❑ Several days ❑ More than half the days ❑ Nearly every day

Home Screening *(please circle yes or no)*

Do you feel safe in your home? **YES / NO**

Do you have any history of physical, emotional, or sexual abuse? **YES / NO**