

Patient Name: _____

**Dr. Ruth Ann Crystal
Gynecologic Intake History**

Reason for today's visit: _____

Is there a phone number where we can leave you a message with personal information such as lab results? Yes No Preferred tel. number(_____)_____

Who is your internist or family doctor? _____

Please check if any of the following apply to you now

- | | | |
|--|--|--|
| <input type="checkbox"/> Weight loss | <input type="checkbox"/> Loss of urine w/cough or sneeze | <input type="checkbox"/> Muscle weakness |
| <input type="checkbox"/> Weight gain | <input type="checkbox"/> Need to wear a pad daily | <input type="checkbox"/> Trouble walking |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Leak if can't get to bathroom fast enough | <input type="checkbox"/> Breast discharge |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Breast mass |
| <input type="checkbox"/> Double/blurred vision | <input type="checkbox"/> Pain with urination | <input type="checkbox"/> Skin rash (specify) |
| <input type="checkbox"/> Spots before eyes | <input type="checkbox"/> Need to urinate often | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Ear ache | <input type="checkbox"/> Incomplete bladder emptying | <input type="checkbox"/> Frequent crying |
| <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Abnormal periods | <input type="checkbox"/> Anxiety/Panic attacks |
| <input type="checkbox"/> Sinus problem | <input type="checkbox"/> Painful intercourse | <input type="checkbox"/> Very dry skin |
| <input type="checkbox"/> Sore throat | <input type="checkbox"/> Frequent diarrhea | <input type="checkbox"/> Abnormal thirst |
| <input type="checkbox"/> Mouth sores | <input type="checkbox"/> Bloody stool | <input type="checkbox"/> Hot flashes |
| <input type="checkbox"/> Dental problems | <input type="checkbox"/> Nausea/vomiting | <input type="checkbox"/> Cuts do not stop bleeding |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Constipation | <input type="checkbox"/> Enlarged lymph nodes |
| <input type="checkbox"/> Difficult breathing on exertion | <input type="checkbox"/> Seizures | <input type="checkbox"/> Seasonal allergies |
| <input type="checkbox"/> Swelling of legs | <input type="checkbox"/> Numbness | |
| <input type="checkbox"/> Heart palpitations | | |
| <input type="checkbox"/> Wheezing | | |
| <input type="checkbox"/> Spitting up blood | | |
| <input type="checkbox"/> Shortness of breath | | |
| <input type="checkbox"/> Chronic cough | | |

Medications that you take including vitamins and over-the-counter meds:

Allergies to medicines or foods (list reaction): _____

Do you have or have you ever had: (Circle all that apply)

- | | | |
|------------------------------------|-----------------------------|---------------------|
| Endometriosis | Uterine fibroids | Ovarian Cysts |
| Blocked tubes | Pelvic/Tubal infection | DES exposure |
| Abnormal pap smear | Freezing/Cryotherapy | LEEP or Cone biopsy |
| Hysterectomy | Gyn. Surgery | Laparoscopy |
| Breast discharge | Cancer of the pelvic organs | |
| Chlamydia | Genital warts | Gonorrhea |
| Herpes | | Trichomonas |
| Gardasil vaccination (HPV vaccine) | | Syphilis |

Patient Name: _____

Fertility history (Skip this section if you are in menopause)

What are you using for contraception? _____

Are you presently nursing (breast feeding) a child? _____

Are you trying to conceive now? _____ **(If no, skip to the next section)**

If yes, how long have you been trying? _____

Have you used (circle) BBT LH kits Fertility treatments

Has your partner had a semen analysis? Yes No

Have you had the chicken pox? Yes No

Are there twins in your family? Yes No

Any Genetic Diseases in your family or your partner's family? Yes No

Obstetrical history

Pregnancy complications (Circle) Toxemia/ Preeclampsia, High blood pressure, Gestational Diabetes, Preterm labor, Congenital abnormalities, Other _____

Delivery complications(Circle) 4th degree tear, Shoulder Dystocia, Other _____

	Year		Year
Full term vaginal births		Miscarriages	
Pre-term vaginal births		Abortions	
Full term cesarean		Ectopic pregnancy	
Pre-term cesarean		# of living children	

Past Medical History (check all that apply to you)

- | | | |
|---|---|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Stroke | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Fracture of _____ |
| <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Blood clot in legs/lungs | <input type="checkbox"/> Hepatitis/ jaundice |
| <input type="checkbox"/> Kidney stone/ infection | <input type="checkbox"/> Cancer of _____ | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Depression | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Mitral valve prolapse | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Special diet |
| <input type="checkbox"/> Need antibiotics for dental work | <input type="checkbox"/> Anemia | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Irregular heart beat | <input type="checkbox"/> Blood transfusions | |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Seizures/epilepsy | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Intestinal problem | |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Glaucoma | |

Past Surgeries/Hospitalizations (list type of surgery and date)

Family history: Do any of the following illnesses run in your family?

M= maternal P= paternal (example M. grandmother, P. aunt)

Illness	Relative	Illness	Relative
Heart Disease		Breast Cancer	
Stroke		Ovarian Cancer	
Hypertension		Uterine Cancer	
Diabetes		Cervical Cancer	
Drinking problem		Colon Cancer	
Blood Clot		Other	

