**Women & Infants**
**Obstetrics and Gynecology Care Center**
(401) 274-1122, ext. 42735

**womenandinfants.org**

## Patient Intake Form

Today's Date: ____________________

Last Name: ____________________ First Name: ____________________ Date of Birth: __________

Pharmacy: ____________________ Pharmacy Phone #: ____________________

Address: ____________________ City: ____________________ State: ______ Zip: __________

Primary Care Provider: ____________________ Phone: ____________________

Address: ____________________ City: ____________________ State: ______ Zip: __________

*Tell us about other providers you see:*

Provider: ____________________ Specialty: ____________________

Address: ____________________ Phone: ____________________

Reason for today's visit: ____________________

____________________

____________________

List any allergies: ____________________

List ALL medications — prescribed, over-the-counter and herbal. *(Please use other side, if needed.)*

| ***Medication, Dose, Frequency*** | ***Medication, Dose, Frequency*** |
|---|---|
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## Past Medical History *(Please check all that apply.)*

- ❑ Acid reflux/heartburn
- ❑ AIDS/HIV
- ❑ Anemia/low blood count
- ❑ Anxiety/depression/other psychiatric history
- ❑ Arthritis
- ❑ Asthma
- ❑ Bladder problem
- ❑ Blood clots
- ❑ Blood disorder
- ❑ Cancer (what kind?) ______________
- ❑ Diabetes
- ❑ Endometriosis
- ❑ Fibromyalgia
- ❑ Glaucoma
- ❑ Headaches/migraines
- ❑ Heart disease
- ❑ Hepatitis
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Kidney disease
- ❑ Lung disease
- ❑ Osteoporosis/osteopenia (bone loss)
- ❑ Stomach/bowel problems
- ❑ Stroke
- ❑ Thyroid disorder
- ❑ Other: ______________

## Surgical History *(Please list any surgery you have had.)*

| *Date of Surgery* | *Type of Surgery* |
|---|---|
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**Have you ever been hospitalized for anything other than deliveries?** ❑ **Yes** ❑ **No**

| *Date of Hospitalization* | *Reason for Hospitalization* |
|---|---|
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## Family History

| | | | | |
|---|---|---|---|---|
| Parent: | ❏ Living | ❏ Deceased | Age ______ | Cause of death ____________________ |
| Parent: | ❏ Living | ❏ Deceased | Age ______ | Cause of death ____________________ |
| Sibling: | ❏ Living | ❏ Deceased | Age ______ | Cause of death ____________________ |
| Sibling: | ❏ Living | ❏ Deceased | Age ______ | Cause of death ____________________ |
| Sibling: | ❏ Living | ❏ Deceased | Age ______ | Cause of death ____________________ |
| Sibling: | ❏ Living | ❏ Deceased | Age ______ | Cause of death ____________________ |

**Have any of your blood relative(s) had any of the following conditions?**
*Please specify their age and relationship.*

| | | *Age* | *Relationship* |
|---|---|---|---|
| ❏ Yes ❏ No | Bipolar disorder | ____ | ____________ |
| ❏ Yes ❏ No | Breast cancer | ____ | ____________ |
| ❏ Yes ❏ No | Colon cancer | ____ | ____________ |
| ❏ Yes ❏ No | Depression | ____ | ____________ |
| ❏ Yes ❏ No | Diabetes | ____ | ____________ |
| ❏ Yes ❏ No | Heart disease | ____ | ____________ |
| ❏ Yes ❏ No | High blood pressure | ____ | ____________ |

| | | *Age* | *Relationship* |
|---|---|---|---|
| ❏ Yes ❏ No | Hyperlipidemia | ____ | ____________ |
| ❏ Yes ❏ No | Kidney disease | ____ | ____________ |
| ❏ Yes ❏ No | Melanoma | ____ | ____________ |
| ❏ Yes ❏ No | Ovarian cancer | ____ | ____________ |
| ❏ Yes ❏ No | Prostate cancer | ____ | ____________ |
| ❏ Yes ❏ No | Stroke | ____ | ____________ |
| ❏ Yes ❏ No | Uterine cancer | ____ | ____________ |

## Social History

Current occupation: ❑ Employed ❑ Unemployed ❑ Student ❑ Homemaker ❑ Retired ❑ Other

Level of education: ______________________________

Marital status: ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed ❑ Domestic partner

What is your gender? ____________________

What was your sex at birth? ❑ Female ❑ Male

Exercise level: ❑ None ❑ Occasional ❑ Moderate ❑ Heavy

Do you follow a special diet? ❑ No ❑ Yes If yes,what kind? ______________________________

Smoking status: ❑ Never a smoker ❑ Former smoker ❑ Smoker Have been smoking since ____ years old

Alcohol intake: ❑ None ❑ Occasional ❑ Moderate ❑ Heavy

Do you use street drugs? ❑ No ❑ Yes If yes, list which one(s)?______________________________

Do you routinely use a seat belt? ❑ No ❑ Yes

## Gynecological History

Age your period began: _____ How often do you get a period? __________ How long does it last? __________

Date of last Pap Smear: ____________ Have you ever had an abnormal Pap Smear? ❑ No ❑ Yes

Are you sexually active? ❑ No ❑ Yes If yes, with? ❑ Men ❑ Women ❑ Both

Current birth control method: ______________________________

Are you interested in discussing birth control today? ❑ No ❑ Yes ❑ Uncertain

Have you ever had a sexually transmitted infection (STI)? ❑ No ❑ Yes If yes, list which one(s)

______________________________________________________________________

Have you ever had an HPV (cervical cancer) vaccine? ❑ No ❑ Yes ❑ Unsure

## Obstetrical History

Have you ever been pregnant? (including miscarriages or abortions) ❑ No ❑ Yes

How many times have you been pregnant? _______

- Number of full term deliveries _______
- Number of premature deliveries _______
- Number of terminations/abortions _______
- Number of miscarriages _______
- Number of tubal (ectopic) pregnancies _______
- Number of twins/triplets _______

How many children living? _______

## Past Pregnancies

| Delivery Date | # of Babies | Weight | Male/ Female | Vaginal/C-Section | Full-term/ Premature | Complications during pregnancy or delivery |
|---|---|---|---|---|---|---|
| 1 | | | | | | |
| 2 | | | | | | |
| 3 | | | | | | |
| 4 | | | | | | |
| 5 | | | | | | |