Capital Women's Care Div 65 | Midwives of Loudoun

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# GYN INTAKE FORM

Name:_____ Date:_____

Preferred Name:_____ DOB:_____

**WHAT IS THE REASON FOR YOUR VISIT?** _____

_____

## GYN HISTORY :

| | | | | | |
|---|---|---|---|---|---|
| Age of first period (Menarche): | | Any recent changes to your menses or concerns about your cycles? | | | |
| First day of last menstrual period (LMP): | | How often do you get your periods? | | Describe your menstrual cycle frequency: | Regular ☐ Irregular ☐ Absent ☐ |
| Have you ever missed school, work, or social activities due to your period? | | | ☐ Yes No ☐ | Are your periods painful? | ☐ Yes No ☐ |
| Describe your menstrual cycle flow: | Light ☐ Normal ☐ Heavy ☐ | Length of your period (days of bleeding) | | Number of pads / tampons on your heaviest day | |
| Current Contraception | | Do you want to discuss birth control options? | ☐ Yes No ☐ | Reason for no birth control | Same Sex Parter ☐ Abstinence ☐ Trying to Concieve ☐ Religion ☐ |
| Do you have any concerns about your breasts? | Discharge ☐ Pain ☐ Lumps ☐ No ☐ | Do you practice breast self-exam? | ☐ Yes No ☐ | Are you Breastfeeding or Pumping? | ☐ Yes No ☐ |

## PREVENTATIVE HEALTH SCREENINGS:

| | | | |
|---|---|---|---|
| Do you have a Primary Care Provider (PCP)? | Yes ☐ No ☐ Who? _____ When was your last appt? _____ | | |
| When was your last Pap test? | | Was it normal? | Yes ☐ No ☐ |
| Have you ever had an abnormal Pap test? | Yes ☐ No ☐ | Have you ever had a cervical procedure? | No ☐ Colpo ☐ LEEP ☐ Cone Biopsy ☐ Cryo ☐ |
| Have you ever had an STI? | Yes ☐ No ☐ If Yes, when?_____ What was the result? | Gonorrheaa ☐ Herpes ☐ Syphilis ☐ HIV ☐ Chlamydia ☐ | |
| Do you want STI testing? | Yes ☐ No ☐ | Have you had the Gardasil vaccine? | Yes ☐ No ☐ |
| Have you ever had a mammogram? | Yes ☐ No ☐ If Yes, when and what was the result? | | |
| Have you ever had any other breast imaging? | Yes ☐ No ☐ If Yes, when and what was the result? | | |
| Have you ever had a DEXA Scan? | Yes ☐ No ☐ If Yes, when and what was the result? | | |
| Have you ever had a colon cancer screen or colonoscopy? | Yes ☐ No ☐ If Yes, when and what was the result? | | |

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## PREGNANCY HISTORY: Have you given birth before? (Leave blank if answer is no)

| DOB | Provider & Location | Baby Name | Weeks at delivery | Baby Weight | Sex M/F | Type of delivery (Vaginal, Caesarean Vacuum, Forceps) | Living Y/N | Complications (GDM, high BP, IUGR, bleeding, shoulder dystocia, etc) |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |

## MISCARRIAGE / TERMINATION HISTORY: Have you ever had a miscarriage or terminated a pregnancy? (Leave blank if answer is no)

| Date | Weeks into Pregnancy | Type (Spontaneous, Induced, or Ectopic) | Management (None, Medication, D&C) | | Date | Weeks into Pregnancy | Type (Spontaneous, Induced, or Ectopic) | Management (None, Medication, D&C) |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |
| | | | | | | | | |

## MEDICATION / SUPPLEMENTS: List all that you take daily and as needed

| Calcium ☐ DHA ☐ Iron ☐ Vitamin D ☐ Folic Acid ☐ Multi Vitamin ☐ Prenatal Vitamin ☐ | | | |
|---|---|---|---|
| **Medication:** | **Dose:** | **Medication:** | **Dose:** |
| **Medication:** | **Dose:** | **Medication:** | **Dose:** |
| **Are there any medications (including supplements, vitamins, herbs or OTC drugs) that you have recently stopped taking?** | | | |

## ALLERGIES: Do you have any medication allergies? (Leave blank if answer is no)

| Allergy: | Reaction: | | Allergy: | Reaction: |
|---|---|---|---|---|
| Allergy: | Reaction: | | Allergy: | Reaction: |

## SOCIAL HISTORY: Please answer the following questions about your daily habits.

| Tobacco Vaping Hookah | Never ☐ Current ☐ Past ☐ | Type: | Frequency: If Past, Years Free | Amount: |
|---|---|---|---|---|
| Marijuana | Never ☐ Current ☐ Past ☐ | Type: | Frequency: | Amount: |
| Illicit Drugs | Never ☐ Current ☐ Past ☐ | Type: | Frequency: | Amount: |
| Alcohol | Never ☐ Current ☐ Past ☐ | Type: | Frequency: | Amount: |
| Caffeine | Never ☐ Current ☐ Past ☐ | Type: | Frequency: | Amount: |
| What is your Activity Level? Sedentary ☐ Walking ☐ Moderate ☐ Vigorous ☐ | | | Do you feel safe at home? | |
| How would you describe your diet? | | | | |

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## MEDICAL HISTORY: Have YOU ever been told that YOU had any of these conditions?

| Condition | Yes | No | Condition | Yes | No | Condition | Yes | No |
|---|---|---|---|---|---|---|---|---|
| Anemia | ☐ | ☐ | Bleeding Disorder* | ☐ | ☐ | Mental Disorder | ☐ | ☐ |
| Anxiety | ☐ | ☐ | Endometriosis | ☐ | ☐ | Pulmonary Embolism | ☐ | ☐ |
| Asthma | ☐ | ☐ | Fibroid Uterus | ☐ | ☐ | Ovarian Cyst | ☐ | ☐ |
| Auto Immune Condition* | ☐ | ☐ | Gallbladder Disease | ☐ | ☐ | Pelvic Inflammatory Disease | ☐ | ☐ |
| Bartholin's Gland Cyst | ☐ | ☐ | Genital Herpes | ☐ | ☐ | Polycystic Ovary Syndrome | ☐ | ☐ |
| Clotting Disorder* | ☐ | ☐ | Migraine With Aura | ☐ | ☐ | Prolapsed Uterus | ☐ | ☐ |
| Breast Lump | ☐ | ☐ | Migraine Without Aura | ☐ | ☐ | Blood Clots In Legs Or Lungs | ☐ | ☐ |
| Cancer* | ☐ | ☐ | Heart Murmur | ☐ | ☐ | Seizure Disorder | ☐ | ☐ |
| Cardiovascular Disease | ☐ | ☐ | High Cholestrol | ☐ | ☐ | Thyroid Disease* | ☐ | ☐ |
| Stroke | ☐ | ☐ | Blood Disorder* | ☐ | ☐ | Tuberculosis | ☐ | ☐ |
| Prolapsed Bladder | ☐ | ☐ | High Blood Pressure | ☐ | ☐ | Urinary Tract Infection, Recurrent | ☐ | ☐ |
| Depression | ☐ | ☐ | Infertility, Female | ☐ | ☐ | Vaginal Infections, | ☐ | ☐ |
| Des Exposure | ☐ | ☐ | Kidney or Renal Disease | ☐ | ☐ | Varicose Veins | ☐ | ☐ |
| Type 1 Diabetes | ☐ | ☐ | Hepatitis / Liver Disease | ☐ | ☐ | Other: | | |
| Type 2 Diabetes | ☐ | ☐ | Heart Disease | ☐ | ☐ | | | |

*If you selected a condition with an asterisk please provide more details:

## SURGICAL HISTORY: What surgeries have you had in the past?

| Surgery | Yes | No | If yes, What year? | Surgery | Yes | No | If yes, What year? |
|---|---|---|---|---|---|---|---|
| Heart Surgery | ☐ | ☐ | | Blood Transfusion | ☐ | ☐ | |
| Appendectomy | ☐ | ☐ | | Chemotherapy | ☐ | ☐ | |
| Arthroscopy | ☐ | ☐ | | Cholecystectomy | ☐ | ☐ | |
| Back Surgery | ☐ | ☐ | | Hysterscopy (D+C) | ☐ | ☐ | |
| Oophorectomy: B ☐ R ☐ L ☐ | ☐ | ☐ | | Gastric Bypass | ☐ | ☐ | |
| Breast Surgery | ☐ | ☐ | | Hernia Repair | ☐ | ☐ | |
| Hysterectomy | ☐ | ☐ | | Myomectomy | ☐ | ☐ | |
| Hip Replacement | ☐ | ☐ | | Thyroidectomy | ☐ | ☐ | |
| Radiation Therapy Procedure | ☐ | ☐ | | Knee Replacement, Total | ☐ | ☐ | |
| Bilateral Tubal Ligation / Salpingectomy | ☐ | ☐ | | Other: | | | |

## FAMILY HISTORY: Do you have any family history of medical illnesses? (Please specify if "Maternal" or "Paternal)

| Disease | Yes | No | Relationship |
|---|---|---|---|
| Autoimmune Disorder | ☐ | ☐ | Relationship to you: Type: |
| Cancer | ☐ | ☐ | Relationship to you: Type: Age at Diagnosis: |
| Cardiovascular Disease | ☐ | ☐ | Relationship to you: Type: |
| Bleeding Disorder | ☐ | ☐ | Relationship to you: Type: |
| Type 1 Diabetes | ☐ | ☐ | Relationship to you: |
| Type 2 Diabetes | ☐ | ☐ | Relationship to you: |
| High Cholesterol | ☐ | ☐ | Relationship to you: |
| Hypertension | ☐ | ☐ | Relationship to you: |
| Stroke | ☐ | ☐ | Relationship to you: |
| Blood Clots in legs or lungs | ☐ | ☐ | Relationship to you: Type: |
| Thyroid Disease | ☐ | ☐ | Relationship to you: Type: |

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## MENOPAUSE: For women who are menopausal or have had their ovaries removed:

| Symptom | Yes | No | Question |
|---|---|---|---|
| Hot Flashes | ☐ | ☐ | Age of Menopause: _____ |
| Insomnia | ☐ | ☐ | Have you ever done hormone replacement therapy? _____ |
| Night Sweats | ☐ | ☐ | If Yes, List HRT Medications: _____ |
| Vaginal Dryness | ☐ | ☐ | Years Taken: _____ |

## ADDITIONAL SYMPTOMS: Do you have any additional topics you would like to discuss? (May incur additional cost):

| Symptom | Yes | No | Symptom | Yes | No |
|---|---|---|---|---|---|
| Abnormal Bleeding | ☐ | ☐ | Waking To Urinate | ☐ | ☐ |
| Anxiety | ☐ | ☐ | Sexual Dysfunction | ☐ | ☐ |
| Decreased Desire For Sex | ☐ | ☐ | Sleep Disturbances | ☐ | ☐ |
| Depression | ☐ | ☐ | Urinary Incontinence | ☐ | ☐ |
| Difficulty Falling Asleep | ☐ | ☐ | Urinary Urgency | ☐ | ☐ |
| Painful Intercourse | ☐ | ☐ | Vaginal Discharge | ☐ | ☐ |
| History Of Infertility | ☐ | ☐ | Vaginal Itching | ☐ | ☐ |
| Other: | | | | | |

## PELVIC PAIN: If you are seeking care today for pelvic pain, please also complete the section below, otherwise, leave blank.

| Question | Yes | No |
|---|---|---|
| Do you have continuous or episodic pelvic pain? | ☐ | ☐ |
| Do you feel that the pain is affecting your quality of life? | ☐ | ☐ |
| Do you have to miss work or other obligations because of the pain? | ☐ | ☐ |
| Is the pain worse during menstrual cycles? | ☐ | ☐ |
| Do you have pain in your lower back that coincides with pelvic discomfort? | ☐ | ☐ |
| Do you experience bloating? | ☐ | ☐ |
| Do you have pain with physical activity? | ☐ | ☐ |
| Do you have pain with intercourse? | ☐ | ☐ |
| Do you have pain with bowel movements? | ☐ | ☐ |