FOR WOMEN HEALTH CARE
Ayodele Olowookere, M.D., P.A.
Obstetrics & Gynecology

GYNECOLOGY INTAKE FORM

Name _____ Date of Birth _____
Email Address: _____
Referring Physician Name & Address _____
Primary Care Physician (if different) _____
Pharmacy Primary: _____ Alternate: _____

What is the reason for your visit today? Is this a routine visit? Yes___ No ___

_____

_____

_____

Describe the problem

_____

_____

When did it start? _____ What does it feel like/what are the symptoms? _____

_____

How severe are the symptoms? (1-10) _____ Where are they located? _____
What makes it better or worse? _____
Have there been previous episodes? _____
Did you seek previous medical care for this problem? _____

Do you have any allergies to medications or other substances? Yes___ No ___
If yes, please list allergies and reactions (rash, hives, throat swelling, anaphylaxis)

_____

_____

Please list ALL of your current medications below (use back of page if you need more room)

MEDICATION NAME	DOSAGE	WHEN DO YOU TAKE IT?	APPROXIMATE START DATE

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MEDICAL HISTORY: Have you ever had (been diagnosed or treated for) any of the following (if yes, describe)

	YES	NO	DESCRIBE
HEART DISORDER			
STOMACH/INTESTINAL DISORDER			
SKIN DISORDER			
CLOTTING DISORDER			
EYE DISORDER			
PSYCHIATRIC DISORDER			
URINARY/KIDNEY DISORDER			
LIVER DISORDER/HEPATITIS			
ORTHOPEDIC DISORDER			
CHOLESTEROL DISORDER			
NEUROLOGIC DISORDER			
DIABETES			
HIGH BLOOD PRESSURE			
ARTHRITIS			
FIBROIDS			
ENDOMETRIOSIS			
CANCER			
THYROID DISORDER			
LUNG DISORDER			
NEUROLOGIC DISORDER			
OTHER			

SURGICAL HISTORY: List any surgeries you have had and the approximate date:
Appendectomy _____ Lapraoscopies _____
Gallbladder _____ Abdominal Surgeries _____
Tubal Ligation _____ Hysterectomy _____
Breast Surgeries _____ Ovaries Removed Yes __ No ___
Others _____
Have you had a blood transfusion? Yes ___ No ____ If yes, when? _____

HEALTH MAINTENACE/DIAGNOSTIC HISTORY:
Last Mammogram _____ Normal __ Abnormal __
Last Bone Density _____ Normal __ Abnormal __
Last Cholesterol _____ Normal __ Abnormal __
Last Colonoscopy _____ Normal __ Abnormal __

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OBGYN HISTORY:
Number of pregnancies _____
Live births ____ Vaginal Deliveries ____ Cesarean Sections ____ Miscarriages ____
Tubal Pregnancies ____ Terminations ____ Living Children ____

When was your last menstrual period? _____ Age of first period _____
How frequently do you have your period? _____
If irregular, describe frequency _____ Is your flow heavy? _____
How many days do you bleed? _____ Do you stain/bleed between regular periods? _____
Do you have pain with periods? _____ If so, describe: _____

If your periods have stopped do you have any symptoms associated with menopause?
Yes ___ No ___ If yes, describe _____
_____

Are you currently sexually active? Yes ___ No ___
Do you have any problems associated with sexual relations? Yes ___ No ___
If yes, describe:
_____

Are you currently in a monogamous relationship? Yes ___ No ___
If yes, partners gender: M __ F __ How long have you been in the relationship? _____
Age at first time of intercourse: _____ Approx. number of partners: _____

Are you currently using birth control? Yes ___ No ___
Trying to get pregnant? Yes __ No __
Current birth control: _____ Are you satisfied with it? Yes __ No __
Describe any side effects:
_____

When was your last PAP Smear? _____
Have you ever had an abnormal PAP? Yes __ No __ If yes, when? _____
If you were told you had HPV describe how you were treated _____
_____
Have you ever been treated for the following? If yes, please check.
Vaginosis ___
Genital Warts ___
Chlamydia ___
Herpes ___
Trichomonas ___
Syphilis ___
Have you ever been tested for HIV? Yes __ No __ When? _____

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FAMILY HISTORY: Please indicate any major conditions/illnesses that your family members have had

	Condition & Description	Living	If deceased, what age?
Mother	_____	_____	_____
Father	_____	_____	_____
Sibling	_____	_____	_____

CONDITION		WHICH RELATIVE:
Cancer Breast:	Yes __ No __	_____
Cancer Colon:	Yes __ No __	_____
Cancer Cervix:	Yes __ No __	_____
Cancer body of uterus:	Yes __ No __	_____
Cancer Ovaries:	Yes __ No __	_____
Cancer other:	Yes __ No __	_____
High Blood Press. :	Yes __ No __	_____
Heart Disease:	Yes __ No __	_____
Stroke:	Yes __ No __	_____
Diabetes Mellitus:	Yes __ No __	_____
Thyroid Disease:	Yes __ No __	_____

Other: _____

SOCIAL HISTORY:

Occupation: _____
Who do you live with at home? _____
Marital Status: _____
Do you exercise regularly? Yes __ No __ Describe routine: _____
Do you have pets in your home? Yes __ No __ Describe: _____
a healthcare proxy? Yes __ No __
Tobacco: Currently? Yes __ No __ Previously? Yes __ No __
Yrs Smoked ____ Packs/Day ____
Are/Were you exposed to 2nd hand smoke at home or work? Yes __ No __
If yes, explain: _____
Other substances:
Alcohol? Yes __ No __ Recreational drugs? Yes __ No __
Describe Use _____

Patient Signature: _____ Date: _____