318 East Main Street
Crosby, MN 56441
(218)546-8375 (800)450-8375
www.centrallakesclinic.com

Patient Information Sticker

GYNECOLOGIC INTAKE HISTORY

Form completed by: _____Self _____Physician ____Other ________________ Date:____/____/____

Past or Current Medical Problems

_________________ ____________________
_________________ ____________________
_________________ ____________________
_________________ ____________________

Surgeries/Hospitalizations

__________________ __________________
__________________ __________________
__________________ __________________
__________________ __________________

OB/GYN History

# of pregnancies_______ # of deliveries_______ # of miscarriages_______ # of abortions_______
# of living children _______ # of adopted children _______
Last menstrual period: _____/_____/_____ Period length/frequency: ______days / every ______days
Birth control method: ____

Previous gynecologic surgery	_______No	_______Yes	_____________________________
Previous abnormal PAP smear	_______No	_______Yes	_____________________________
Previous sexually transmitted disease	_______No	_______Yes	_____________________________
Current pelvic pain	_______No	_______Yes	_____________________________
More than 4 sexual partners	_______No	_______Yes	_____________________________
Younger than 16 at first intercourse	_______No	_______Yes	_____________________________

Medications

_________________ ____________________
_________________ ____________________
_________________ ____________________

Allergies

______ No Known Allergies __________________
__________________ __________________
__________________ __________________

Social History

Smoking:	______ No	______ Yes	packs per day:________	# years of use: _________
Alcohol:	______ No	______ Yes	drinks per day:________	drinks per week:_ _______
Illicit Drugs:	______ No	______ Yes	type:________________	frequency: ______________

Marital Status: _________single ________ married ________ divorced ________ widowed
School Completed: ______ high school ______ college ______ graduate ______ other___________
Occupation: ______________________________ Hobbies: ______________________________
Abuse History: ________ physical ________ sexual ________ verbal / emotional

Immunizations

Tetanus (year)______ Influenza (year)______ Pneumonia (year)______ Hepatitis B (year)______

Family History

Mom: ______ alive - current age: ______ ______deceased - age of death: ______ cause: ___________
Dad: ______ alive - current age: ______ ______deceased - age of death: ______ cause: ___________

Illnesses:

Illness	No	Yes	
High Blood Pressure	______ No	______ Yes	____________________
Diabetes	______ No	______ Yes	____________________
Heart Disease	______ No	______ Yes	____________________
Osteoporosis	______ No	______ Yes	____________________
Cancer	______ No	______ Yes	____________________
Stroke	______ No	______ Yes	____________________

Review of Systems

	No	Yes	
1.) Constitutional:			
weight changes	_______No	_______Yes	____________________
fatigue	_______No	_______Yes	____________________
2.) Skin/Breast:			
pain or mass in breast	_______No	_______Yes	____________________
nipple discharge	_______No	_______Yes	____________________
skin lesion	_______No	_______Yes	____________________
3.) Eyes:			
vision problems	_______No	_______Yes	____________________
4.) ENT/Mouth:			
hearing problems	_______No	_______Yes	____________________
sinus problems	_______No	_______Yes	____________________
dental problems	_______No	_______Yes	____________________
5.) Cardiovascular:			
chest pain/shortness of breath	_______No	_______Yes	____________________
swelling in legs	_______No	_______Yes	____________________
palpitations of heart	_______No	_______Yes	____________________
6.) Respiratory:			
wheezing or cough	_______No	_______Yes	____________________
7.) Gastrointestional:			
nausea or vomiting	_______No	_______Yes	____________________
diarrhea or constipation	_______No	_______Yes	____________________
blood in stool	_______No	_______Yes	____________________
8.) Urinary:			
pain with urination	_______No	_______Yes	____________________
blood in urine	_______No	_______Yes	____________________
incontinence	_______No	_______Yes	____________________
9.) Hematological:			
frequent bruising	_______No	_______Yes	____________________
cuts do not stop bleeding	_______No	_______Yes	____________________
enlarged lymph nodes	_______No	_______Yes	____________________
10.) Psychiatric:			
depression	_______No	_______Yes	____________________
anxiety	_______No	_______Yes	____________________

Signature of Patient: ____ **Date:** _____/_____/_____

Health Care Maintenance

Mammogram: ____
Colonoscopy: ____
Dexascan: ____
Lipid Profile (Cholesterol): ____
Pap Smear: ____

Reviewed by Physician:

Date: _____/_____/_____ **Physician Signature:** ____