Adams Patterson Gynecology & Obstetrics

A DIVISION OF WOMEN'S CARE CENTER OF MEMPHIS

Patient Intake Questionnaire

Name_____ Date_____ Account#_____

Age_____ Reason for visit_____Date of last period:_____

Are you having any symptoms that are currently bothering you?_____ If using any type of birth, control please list it here: _____

Please list any allergies to medications or any other things._____ What is the total number of pregnancies you have had?_____ Miscarriages?_____ Living children?_____

How many vaginal births?_____

How may C-sections? _____

Largest birth weight? _____ Preferred Pharmacy Name and Phone # or address_____

If you have previously had any of the following test, please insert the approximate date of the most recent test if known:

Test	Date	Result
Pap		Normal □ Abnormal □
Mammogram		Normal □ Abnormal □
Bone Density		Normal □ Abnormal □
Other		Normal □ Abnormal □

Have you had any gynecological problems in the past? If yes, please list.	Yes □ No □
Have you had any abnormal pap smears before? List any treatments.	Yes □ No □
Have you had any surgery on the uterus, ovaries, tubes, cervix or genital area? Please list.	Yes □ No □
Have you had any complications during pregnancy? Please list	Yes □ No □

Please check any of the follow conditions that you or a close family member may have had:

Condition	Personal History	Family History	Condition	Personal History	Family History
Heart disease			Blood clots in legs or lungs		
Hypertension			Stroke		
Diabetes			Genetic problems		
Autoimmune Disease			Birth Defects		
Stomach ulcer or Reflux			Thyroid problems		
Hepatitis/Liver Disease			Breast or Ovarian Cancer		
Infertility			Colon Cancer		
Asthma			Any Cancer, Type_____		
Anxiety			STD, Type_____		
Depression			Surgery, Type_____		
PMS			Neurologic problems		
Migraine headaches			Blood Clotting disorders		
Urinary			Bleeding disorders		
High Cholesterol			Osteopenia or osteoporosis		
Kidney problems			Other_____		

Comments:

Are you currently having any symptoms that are bothering you with any of the following body systems?			
Body System	**Type of Symptom**	**Body System**	**Type of Symptom**
General		Bladder/Bowels	
Head		GYN/Vaginal	
Eyes		Hormones	
Ears, Nose, Throat		Allergy	
Neck		Skin	
Breast		Muscles or skeletal	
Heart		Fatigue	
Lungs		Psychological	
Gastrointestinal		Urinary	
Stomach		Other	
Trauma/Violence		Other	

Current Medications/Prescriptions			
Name	**Dose**	**Frequency**	**Prescribing Physician**

Over the counter medicines/vitamins/herbal therapies		

Are you … married □ single □ divorced □	
Have you ever been sexually active?	Yes □ No □
Are you currently sexually active?	Yes □ No □
Have you or your current partner had any other partners in the last year?	Yes □ No □
If you are between 12 and 26 years old, have you received the Gardisil Vaccine for cervical cancer?	Yes □ No □ Not applicable □
Do you drink alcohol?	Yes □ No □
Do you drink more than 2 drinks per day on a regular basis?	Yes □ No □
Do you smoke cigarettes?	Yes □ No □
If yes, how many packs per day?_____ How Years have you smoked?_____	
Do you exercise regularly? Type of exercise_____	Yes □ No □

Patient Name&Account #_____