SGCMH
Ste. Genevieve County Memorial Hospital

Women's Wellness Services

Gynecologic Intake History

Patient's Name: _____ Birth Date: ____ / ____ / ____ Age: ____

Reason for appointment: What are you here for today? _____

Were you referred by another physician or Nurse Practitioner? ☐ Yes ☐ No If Yes, Name of Referring Provider: _____

Lab used? ☐ Ste. Genevieve Hospital ☐ Quest ☐ Lab Corp ☐ Other _____ Preferred Pharmacy _____

☐ Covid Vaccine--Date: _____ ☐ Flu Vaccine--Date: _____ ☐ Gardasil Vaccine--Date: _____

Allergies: _____

CURRENT MEDICATIONS: Please list all medications that you are CURRENTLY taking including dose and how often you take it.

Medication Name	Dosage(s)	How Often?	Medication Name	Dosage(s)	How Often?

MEDICAL HISTORY: Please check (✓) any boxes that apply to YOU now or have applied in the past

MAJOR ILLNESS	Yes	No	MAJOR ILLNESS	Yes	No
Asthma	☐	☐	Cancer	☐	☐
Anxiety	☐	☐	Depression	☐	☐
Kidney Disease	☐	☐	Seizures	☐	☐
Heart Disease	☐	☐	Blood Clots in Legs/Lungs	☐	☐
Diabetes	☐	☐	Thyroid Problems	☐	☐
High Blood Pressure	☐	☐	Glaucoma	☐	☐
Eating Disorders	☐	☐	Gallbladder Disease	☐	☐
Migraines	☐	☐	Sickle Cell Disease/Trait	☐	☐
Bleeding Disorders	☐	☐	Uterine Abnormality	☐	☐
Breast Disease	☐	☐	Infertility	☐	☐
Blood Transfusion	☐	☐	Osteoporosis	☐	☐
Tuberculosis	☐	☐	Other:	☐	☐
High Cholesterol	☐	☐	Other:	☐	☐
Hepatitis	☐	☐	Other:	☐	☐

FAMILY HISTORY: Please mark the following items that apply to any immediate family member.

	None	Mother	Father	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Sister	Brother	Maternal Aunt	Paternal Aunt	Maternal Uncle	Paternal Uncle
Breast Cancer													
Ovarian Cancer													
Uterine Cancer													
Colon Cancer													
Blood Clots in Legs/Lungs													
Blood Clotting Disorders													
Problem w/ Anesthesia													
Heart Disease													
Diabetes													
Osteoporosis													
Other:													

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WWS-GYNECOLOGIC INTAKE HISTORY, CONT.

SOCIAL HISTORY: Personal Habits

Smoking Status: ☐ Current Everyday Smoker ☐ Former Smoker ☐ Never Smoker ☐ E-Cigarrete Use ☐ Smoker-Current Status Unk

☐ Tobacco use in past 30 days ☐ E-Cigarette use in past 30 days Packs per day:_____ Years:_____

If yes are you interested in quitting? ☐ Yes, ready to quit ☐ No, not ready at all ☐ Thinking about quitting

How many alcoholic drinks do you typically consume in one week? _____

Recreational Drug use ☐ Yes ☐ No If yes, what?_____

Personal Profile

Marital Status: Married ☐ Single ☐ Widowed ☐ Divorced ☐

How do you identify? ☐ Female ☐ Other _____ Occupation: _____

Are you disabled? ☐ YES ☐ NO If so, why? _____

Personal Safety

	Yes	No
Has anyone close to you ever threatened to hurt you?	☐	☐
Has anyone ever hit, choked, or hurt you physically?	☐	☐
Has anyone, including your partner, ever forced you to have sex?	☐	☐
Are you ever afraid of your partner?	☐	☐

PAST SURGERIES and HOSPITALIZATIONS: Please date and list ALL past Surgeries and Hospitalizations.

OB/GYN HISTORY

Total number of:

- Pregnancies _____
- Deliveries _____
- Miscarriages _____
- Abortions _____
- Living Children _____
- Vaginal Births _____
- Adoptions _____
  - Forceps used? ☐ Yes ☐ No
  - Vacuum used? ☐ Yes ☐ No
- Caesarean Births _____

How much did the largest infant weigh? _____

Complications:

How old were you when your period began? _____

How long do your periods last (from the first day to the last day of one period)? _____

What is the length of your cycle (from the first day of one period to the first day of the next period)? _____

Is your bleeding

What was the first day of your last period? _____

Are you sexually active? ☐ Yes ☐ No

Sexually active with: ☐ Men ☐ Women ☐ Both

What is your current method of birth control? _____

Do you have any sexual concerns? ☐ Yes ☐ No If yes, explain _____

Do you have a history of post-menopausal bleeding? ☐ Yes ☐ No

Do you have a history of post-menopausal hormone therapy? ☐ Yes ☐ No

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WWS- GYNECOLOGIC INTAKE HISTORY, CONT.

"HIGH RISK" CRITERIA: Please check (✓) if you have ever been treat for any of the following infections:						
Vaginosis ☐	Genital Warts ☐	Chlamydia ☐				
Trichomonas ☐	Gonorrhea ☐	Syphilis ☐				
	HIV ☐	HPV ☐				
Uterine surgeries? ---☐Myomectomy Other: _____						
Have you ever had an abnormal Pap smear test?					☐Yes ☐No	If yes, diagnosis?
Did you have high risk HPV?					☐Yes ☐No	
Did you have the following? ☐ Colposcopy ☐ LEEP/Conization ☐ Cryotherapy						
Did you begin sexual activity before you were 16 years old?					☐Yes ☐No	
Have you had more than 5 sexual partners in your lifetime?					☐Yes ☐No	
Have you ever tested positive for HIV?					☐Yes ☐No	
Did your mother take the drug DES when she was pregnant with you?					☐Yes ☐No	
Have you ever had Genetic Testing?					☐Yes ☐No	

REVIEW OF SYSTEMS: Please check the following items that apply to you NOW			
1. General			**Notes**
☐ Fatigue	☐ Weight Gain	☐ Night Sweats	
☐ Fever	☐ Weight Loss	☐ Sleep Disturbances	
2. Skin			
☐ Acne	☐ Rash	☐ Eczema	
☐ Dry Skin			
3. Neurologic			
☐ Headache	☐ Dizziness	☐ Seizures	
4. Genitourinary			
☐ Frequent urination	☐ Painful Urination	☐ Loss of Urine	
5. Cardiovascular			
☐ Chest Pain	☐ Palpitations		
6. Breast			
☐ Breast Lump	☐ Breast Pain	☐ Nipple Discharge	
7. Respiratory			
☐ Shortness of breath	☐ Cough	☐ Wheezing	
8. Gastrointestinal			
☐ Nausea	☐ Diarrhea	☐ Abdominal Pain	
☐ Vomiting	☐ Constipation		
9. Female Reproductive			
☐ Heavy Menses	☐ Painful Intercourse	Pelvic Pain	
☐ Irregular Menses	☐ Vaginal Discharge	☐ Vaginal Odor	
☐ Missed Period	☐ Hot Flashes	☐ Vaginal Itching	
☐ Painful Menses			
10. Psychiatric			
☐ Anxiety	☐ Depressed Mood		
11. ENT			
☐ Nose Bleeds	☐ Sore Throat		
12. Musculoskeletal			
☐ Muscle Aches	☐ Joint Pain	☐ Weakness	
Would you like a chaperone in the room for you exam? Yes ☐ No ☐			

Is this your first visit with us? If so, who did you see prior? _____
Please sign a record release form at the front desk if you haven't already if this is your first time seeing us.
I attest to the best of my knowledge that the above information is true and accurate. I also may be subjected to random drug testing.

Patient's Signature: _____ Date: _____