Patient Medical History Intake Form

Women's Care at Tufts

Please complete BOTH SIDES of this form!

Please fill this form out as completely as possible. It will help us to take the best possible care of you. If you have questions, please ask for help.

Name of Patient: _____ Birth Date: _____ Date: _____
Name of Spouse/Partner:_____
If you are here with a relative, his/her name?_____relationship to you?_____

What brings you in today? What gynecologic concerns do you have?

_____

Obstetric/Gynecologic History

Number of Births _____ Number of vaginal deliveries _____ Number of Cesarean Sections _____
Pregnancy Complications (eg. Preeclampsia? Gestational diabetes? Preterm delivery?)_____
_____
Number of Miscarriages _____ Number of Abortions _____ Number of Living children _____

Are you planning a pregnancy in the next year? Yes ( ) No ( )

Usual number of days from the beginning of one period to the beginning of the next _____
Are your periods regular or irregular? _____

Type of contraception you are currently using? _____
Types of contraception used in the past (birth control pills, IUD, Depo-Provera injection etc.) _____

Have you ever had an abnormal pap smear? Yes ( ) No ( )
If so, when and how was it treated? _____
When was your last pap smear (cervical cancer screening test)? _____

Have you ever had an infection in your uterus or cervix (sexually transmitted disease)?_____
If so, what kind? (circle) PID Herpes Genital warts HIV/AIDS Syphilis Chlamydia Gonorrhea Trichomoniasis

Did you receive the HPV (human papilloma virus) vaccine? Yes ( ) No ( ) Did you get all three injections? Yes ( ) No ( )

Sexual History (If you prefer to discuss in person with your provider, feel free to wait until you see him/her.)
What is your current gender identity? (Check all that apply)
female ( ) male ( ) transgender male ( ) transgender female ( ) other_____

Do you think of yourself as:
lesbian or homosexual ( ) straight or heterosexual ( ) bisexual( ) other_____

Are you having sex? Yes ( ) No ( ) If yes:
Do you have sex with: men( ) women ( ) both ( )
Do you have: oral ( ) vaginal ( ) anal sex ( )

Any new sex partners within the past three months? Yes ( ) No ( )

Do you use condoms? always ( ) sometimes ( ) never ( )

FLIP FORM OVER TO COMPLETE PAGE 2!

Patient Name _____ Birth Date _____

Medical History – Please list all of your medical problems

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Allergies to Medications? _____ **reaction?**_____

_____ **reaction?**_____

_____ **reaction?**_____

Surgical History – please list all of your previous surgeries

1. Date_____ Surgery_____ 4. Date_____ Surgery_____
2. Date_____ Surgery_____ 5. Date_____ Surgery_____
3. Date_____ Surgery_____ 6. Date_____ Surgery_____

Other Hospitalizations/Injuries

Date_____ Reason_____

Date_____ Reason_____

Family History

Are your parents still living? Mother: Yes ( ) No ( ) Father: Yes ( ) No ( )

	Yes	Which Relative?		Yes	Which Relative?
Diabetes	( )	_____	Breast Cancer	( )	_____
Stroke	( )	_____	Colon Cancer	( )	_____
Heart Disease	( )	_____	Ovarian Cancer	( )	_____
High Blood Pressure	( )	_____	Uterine Cancer	( )	_____

Family member with history of blood clot in leg or lung? Yes ( ) Relative _____

Social History

	Yes	No	
Smoker	( )	( )	Number packs per day _____ Number of years smoking _____
Former smoker	( )	( )	When did you quit? _____ How many years did you smoke? _____
Drink alcohol	( )	( )	Number of drinks per day _____Per week _____
Drug use	( )	( )	Type of drug used _____
Regular exercise	( )	( )	Type of exercise _____
Calcium supplements	( )	( )	Dose each day _____

Marital Status Married ( ) Single ( ) Widowed ( ) Divorced ( )

People living in your household _____

Do you feel safe at home? Yes ( ) No ( )

School completed : High School ( ) College ( ) Graduate Degree ( ) Other ( )

Have you ever been in the military? Yes ( ) No ( )

Current or most recent job _____