SWEDISH MEDICAL GROUP

NEW PATIENT INTAKE FORM

Today's Date:_____Name: _____Date of Birth:_____Age: _____
Occupation:_____Partner's name: _____Partner's gender: _____
Non-OB/GYN Primary Doctor:_____Reason for Visit/concerns:_____
Medical Allergies/Reactions:_____
_____
Current Medications/Dose (including birth control, over-the-counter medications and supplements):
_____
_____

Menstrual History:
How old were you when you first started your period? ___ Are you having periods? ☐ Y ☐ N (If no, skip to *)
First day of last period: _____ Are your periods monthly? ☐ Y ☐ N How many days do you bleed?_____
How many days is your cycle (from start of period to start of the next period)?_____
On your heaviest days, how often do you change your pad/tampon? _____
Do you have irregular periods? ☐ Y ☐ N List any problems with your periods: _____

*If you are through menopause, have you had any bleeding at all? ☐ Y ☐ N
*If menopausal, at what age did your periods stop? ____

Sexual history:
Are you sexually active? ☐ Y ☐ N Sexual preference: ☐ men ☐ women ☐ both
Any new partners in the last year? ☐ Y ☐ N How long with current partner?_____
Birth Control Method:_____ Do you want to be tested for STDs? ☐ Y ☐ N

Date of most recent: Pap:_____ HPV Vaccine: _____Tdap vaccine: _____

Mammogram: _____Colonoscopy:_____ Blood work:_____ Bone density: _____

Gynecologic History:
Please **CHECK** if you have or have ever had:

☐ Abnormal Pap
☐ Colposcopy
☐ Laser/Cryosurgery/Freezing/Cone Biopsy/LEEP
☐ Cervical Cancer
☐ Ovarian Cancer
☐ Uterine Cancer
☐ Breast Cancer
☐ Colon Cancer
☐ Genital Sores
☐ Genital Herpes
☐ Genital Warts (Condyloma)
☐ Gonorrhea
☐ Chlamydia
☐ Infertility
☐ Sexual Problems
☐ Painful Intercourse
☐ Trichomonas
☐ Syphilis
☐ Pelvic Inflammatory Disease (PID)
☐ Hepatitis
☐ HIV
☐ Endometriosis
☐ Uterine Fibroids
☐ Fibrocystic Breast
☐ Breast Biopsy or Surgery
☐ Previous IUD
☐ Birth Control Pills
☐ Tubal Ligation
☐ Hormone Therapy
☐ Bladder Problems or Pelvic Prolapse
☐ Ovarian Cyst
☐ Lack of Sexual Desire

If you were born before 1972, did your mother take Diethylstilbestrol (DES) when pregnant with you?
☐ Y ☐ N ☐ Unknown

Pregnancy History
List all pregnancies, including miscarriages and/or abortions

Year	Duration (Mos/Wks)	Labor length	Weight	Sex	Name	Delivery Type	Hospital	Complications (High BP, pre-eclampsia, hemorrhage, shoulder dystocia, diabetes, etc). Please list.

Personal Medical History: Please **CHECK** if **YOU** have or have ever had:

- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Pneumonia
- ☐ Asthma
- ☐ Tuberculosis
- ☐ Hepatitis
- ☐ Gallstones
- ☐ Colitis
- ☐ Ulcers
- ☐ Cancer
- ☐ Varicose Veins
- ☐ Blood clot in the leg or lung (DVT or PE)
- ☐ Migraines
- ☐ Recurrent Urinary Infections
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ Skin Disease
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Autoimmune Disease
- ☐ Lupus
- ☐ Anemia
- ☐ Blood Transfusion
- ☐ Seizure
- ☐ Stroke

If you checked any of the above, or have **OTHER** significant medical history, please provide date and relevant comments: _____

_____

Surgical history: Please list any surgery and date: _____

_____

_____

Family History ☐ Check if you were adopted and do not know your family history

Please state which relatives have had the following and their age at diagnosis:

Breast cancer _____ Deep Vein Clots _____
Ovarian cancer _____ Stroke _____
Uterine cancer _____ Diabetes _____
Colon cancer _____ Thyroid Disease _____
Other cancer _____ Osteoporosis (Brittle Bones) _____
Heart Attack _____ Birth Defects _____
High Blood Pressure _____ Other _____

Health Habits

Have you used tobacco? ☐ Y ☐ N Circle: Smoke, Vape, Chew
Amount per day:_____How Long:_____
Are you planning to or when did you quit?_____
Alcohol: Drinks per week:_____Quit:_____
Drug use: _____Quit:_____
Do you have any objections to blood transfusion? ☐ Y ☐ N
Caffeine per day:_____
What is your exercise regimen? _____
How would you describe your diet?_____
If you bike, do you use a helmet? ☐ Y ☐ N
Do you use a seat belt? ☐ Y ☐ N
How often do you perform breast self-exams? _____
What is your daily calcium intake (diet and/or supplements)? _____
What is your daily Vitamin D intake? _____
Do you have any history of sexual abuse? ☐ Y ☐ N
Do you feel safe at home/work? ☐ Y ☐ N