ADVANCED CALIFORNIA MEDICAL CENTER, INC. ~ GYNECOLOGIC INTAKE HISTORY

PATIENT NAME: _____ DOB: _____/_____/_____ DATE: _____/_____/_____

REVIEW OF SYMPTOMS

*** PLEASE CHECK (X) IF ANY OF THE FOLLOWING APPLY TO YOU NOW, IN THE PAST, OR OFTEN ***

	Yes	No		Yes	No
1. CONSTITUTIONAL			**2. EYES**		
Weight Loss	☐	☐	Double Vision	☐	☐
Weight Gain	☐	☐	Spots Before Eyes	☐	☐
Fever	☐	☐	Vision Changes	☐	☐
Fatigue	☐	☐	Explain YES Answers:		
Explain YES Answers:					
3. ENT / MOUTH			**4. CARDIOVASCULAR**		
Ear Aches	☐	☐	Panful Breathing	☐	☐
Ringing in Ears	☐	☐	Chest Pain	☐	☐
Sinus Problems	☐	☐	Difficult Breathing on Exertion	☐	☐
Sore Throat	☐	☐	Swelling of Legs	☐	☐
Mouth Sores	☐	☐	Palpitations of Heart	☐	☐
Dental Problems	☐	☐	Explain YES Answers:		
Explain YES Answers:					
5. RESPIRATORY			**6. GASTROINTESTINAL**		
Wheezing	☐	☐	Diarrhea, frequent	☐	☐
Spitting Up Blood	☐	☐	Bloody Stool	☐	☐
Shortness of Breath	☐	☐	Nausea / Vomiting	☐	☐
Cough, chronic	☐	☐	Constipation	☐	☐
Explain YES Answers:			Explain YES Answers:		
7. GENITOURINARY			**8. MUSCULOSKELETAL**		
First day of last menstrual period _____ (Date)			Muscle Weakness	☐	☐
Pain with Urination	☐	☐	Back Pain	☐	☐
Urgency	☐	☐	Arthritis	☐	☐
Frequency of Urination	☐	☐	Explain YES Answers:		
Blood in Urnine	☐	☐			
Incontinence	☐	☐			
Abnormal Periods	☐	☐			
Painful Intercourse	☐	☐			
Explain YES Answers:					
9. SKIN / BREAST			**10. NEUROLOGICAL**		
Pain in Breast	☐	☐	Dizziness	☐	☐
Discharge	☐	☐	Seizures	☐	☐
Masses	☐	☐	Numbness	☐	☐
Rash	☐	☐	Trouble Walking	☐	☐
Ulcers	☐	☐	Explain YES Answers:		
Explain YES Answers:					
11. PSYCHIATRIC			**12. ENDOCRINE**		
Depression	☐	☐	Dry Skin	☐	☐
Anxiety	☐	☐	Abnormal Thirst	☐	☐
			Hot Flashes	☐	☐
Explain YES Answers:			Explain YES Answers:		
13. HEMATOLOGIC / LYMPHATIC			**14. ALLERGIC / IMMUNOLOGIC**		
Bruises, frequent	☐	☐	Allergies	☐	☐
Cuts Do Not Stop Bleeding	☐	☐	Drugs, Other	☐	☐
Enlarged Lymph Nodes	☐	☐	Explain YES Answers:		
Explain YES Answers:					

PERSONAL PAST HISTORY

Major Illnesses	Yes	No			Yes	No
Asthma				Cancer		
Pneumonia				Ulcers		
Chronic Lung Disease				Depression / anxiety		
Kidney Infections / Stones				Anemia / Blood Transfusions		
Tuberculosis				Seizures / convulsions / Epilepsy		
Veneral Disease				Bowel Trouble		
Heart Trouble / Murmur				Glaucoma		
Diabetes				Arthritis / Joint Pain		
High Blood Pressure				Fracture		
Stoke				Hepatitis / Yellow Jaundice		
Rheumatic Fever				Thyroid Disease		

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PATIENT NAME: _____ DOB: _____/_____/_____ DATE: _____/_____/_____

Operations		Hospitalizations	
Type:	Date	Reason:	Date

PREGNANCIES

Live Births				Miscarriages	Abortions
Date	Birth Wt.	Type Delivery	Place of Delivery	Date	Date

CURRENT MEDICATIONS

Drug Name:	Dosage		Drug Name:	Dosage

FAMILY HISTORY

Illness	Yes/No	Relative	Illness	Yes/No	Relative
Diabetes			Breast Cancer		
Stroke			Colon Cancer		
Heart Disease			Ovarian Cancer		
High Blook Pressure			Other		

SOCIAL HISTORY

HABITS

Smoking	yes ☐	no ☐	Packs per day: _____	Years: _____
Alcohol	yes ☐	no ☐	Drinks per day: _____	Drinks per week: _____
Drug Use	yes ☐	no ☐		

PERSONAL PROFILE

Marital Status	Married ☐	Single ☐	Widowed ☐	Divorced ☐
School Completed	High School ☐	College ☐	Graduate Degree ☐	Other ☐
Current or most recent job:				

Additional Comments:

Signature of patient: _____

Date reviewed by physician with patient: _____/_____/_____

Physician Signature: _____

ANNUAL REVIEW OF HISTORY

Date reviewed: _____/_____/_____ Physician Signature: _____

Date reviewed: _____/_____/_____ Physician Signature: _____

Date reviewed: _____/_____/_____ Physician Signature: _____