IVANA MD
Gynecology • Sexual Health • Intimacy Coaching

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PATIENT INTAKE HISTORY

Patient Name:	Date of Birth:	Date:
Address:		
City:	State/Zip	
Home Telephone :	Work Telephone:	
Cellular Telephone:		
Employer:		
Insurance Company:	Policy #	Group #
Insurance Co Telephone:	Guarantor Name:	
Guarantor Date of Birth:	Guarantor SS#:	
Name of Spouse/Partner:	Emergency Contact Name:	
Referred By:	Relationship:	
How did you hear about us?	Home Telephone:___________	Work Telephone:___________
Please describe your current medical problem, including where it is, how severe it is and how long it has lasted.		

If you are uncomfortable answering any questions, please leave them blank, you can discuss them with your doctor or nurse

Allergies to medications: ____

Allergies to Latex: Y ☐ N ☐

Gynecologic History

	Physician's Notes
Last Normal Menstrual period (First Day):	
Age Period began:	
Length of periods (Number of days bleeding):	
Number of days between periods:	
Any recent changes in periods:	
Are you currently sexually active?	
Have you ever had sex?	
Sexual partners are ☐ men ☐ women ☐ both	
Present method of birth control?	
Have you ever used an intrauterine device (IUD) or birth control pills?	
If yes, for how long?	
When was your last Pap Test?	
What was the result?	
Have you ever had an abnormal pap test?	
Do you do breast self-examinations?	
Have you been exposed to Diethylstilbestrol (DES)? Y N	

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PATIENT INTAKE HISTORY (Continued)

Patient Name Date of Birth Date

Obstetric History

	Number		Number		Number
Pregnancies		Abortions		Miscarriages	
Premature Births (<37 wks)		Live Births		Living children	

No.	Date of Birth	Weight at Birth	Baby's Sex	Wks Pregnant	Type of Delivery (Vaginal, cesarean, etc.)	Physician's Notes
1.						
2.						
3.						
4.						
5.						

Any pregnancy complications?

☐ Diabetes ☐ Hypertension/High Blood Pressure ☐ Pre-eclampsia/Toxemia ☐ Other

Any history of depression before or after pregnancy? ☐ No ☐ Yes, How treated

Current Medications

(Including hormones, vitamins, herbs, nonprescription medications)

Drug Name	Dosage	Who Prescribed	Drug Name	Dosage	Who Prescribed

Family History

Illness	Yes	Which Relative(s) and age of onset	Physician's Notes
Diabetes	☐		
Stroke	☐		
Heart Disease	☐		
Blood Clots in lungs or legs	☐		
High blood pressure	☐		
High cholesterol	☐		
Osteoporosis (weak bones)	☐		
Hepatitis	☐		
HIV/AIDS	☐		
Tuberculosis	☐		
Birth Defects	☐		

Family History - contd.

Alcohol or drug problems	□		
Breast cancer	□		
Colon cancer	□		
Ovarian cancer	□		
Uterine cancer	□		
Mental illness/depression	□		
Alzheimer's disease	□		
Other	□		

Social History

	Yes	No	Physician's Notes
Ever Smoked? Current Smoking: Packs per day: __________ Years: ________________________________	□	□	
Alcohol Drinks per day: ______________ Drinks per week: _ Types of Drink: ______	□	□	
Drug Use Yes No	□	□	
Seat Belt Use	□	□	
Regular Exercise: How long and how often?	□	□	
Dairy Product intake and/or Calcium supplements: Daily Intake: ____	□	□	
Health hazards at home or work?	□	□	
Have you been sexually abused, threatened, or hurt by anyone?	□	□	

Personal Profile

Past Medical History and Review of Systems Check any or all that apply to you whether you are experiencing now or have ever

□ High Blood Pressure □ Swollen Ankles □ Bronchitis □ Indigestion □ Ulcer
□ Diabetes □ Palpitations □ Pneumonia □ Nausea □ Colitis
□ Cancer □ Persistent Cough □ Lightheaded □ Vomiting □ Arthritis
□ Heart Disease □ Frequent urination □ T.B. □ Constipation □ Anxiety
□ Chest pain □ Rheumatic fever □ Hay Fever □ Diarrhea □ Depression
□ Shortness of breath □ Asthma □ Abdominal discomfort □ Blood in Stool □ Anemia
□ Headache □ Kidney disease □ Gall Bladder disease □ Alcohol Abuse □ Change in Bowel Habits
□ Unexplained wt gain □ Kidney Stones □ Hepatitis or Jaundice □ Thyroid Disease □ Drug Abuse
□ Blood disorders □ Difficulty urinating □ Hemorrhoids □ Skin Diseases □ Low Back Problems
□ Other ____

When was your last:

□ Cholesterol check
□ Mammogram ____________________ □ Colon Cancer Test ____________________
□ Breast Exam ____________________
□ Physical ____________________

Hospitalization / Surgeries ☐ None	____________________ ____________________ ____________________
Form completed by: ☐ Patient ☐ Office Nurse ☐ Physician ☐ Other	
Signature of Patient	
Date Reviewed by Physician with Patient:	Physician Signature