PROVIDENCE
Medical Group
Women's Services

PATIENT LABEL

INTAKE HEALTH HISTORY

Today's Date: _____

Name: _____DOB: _____ Age: _____ Preferred pronoun: She/He/They/Other_____

Primary Care Provider: _____Occupation: _____

Reason for today's visit: _____

Pharmacy Name AND Location _____

MEDICATION ALLERGIES/REACTION: Are you allergic to any medications? ☐ Yes ☐ No

Drug Name	Reaction	Drug Name	Reaction
_____		_____	
_____		_____	

CURRENT MEDICATIONS: (Please include prescription drugs, over-the-counter, vitamins, herbals, and supplements)

_____

_____

GYNECOLOGIC HISTORY:

Age at first period: _____ First day of last period: _____ Days of flow: _____ Periods are: ☐ Regular ☐ Irregular

Concerns about period: _____

Date of last pap smear: _____ ☐ Normal ☐ Abnormal History of abnormal paps: _____

Have you received the HPV vaccination series? ☐ Yes ☐ No

Date of last mammogram: _____ ☐ Normal ☐ Abnormal History of abnormal mammograms: _____

Do you partner with: ☐ Men ☐ Women ☐ Both

Do you currently experience any of the following?

Yes No				**Please Describe**
☐ ☐ Vaginal itching or bothersome discharge	Mild	Moderate	Severe	_____
☐ ☐ Pelvic cramping	Mild	Moderate	Severe	_____
☐ ☐ Abnormal Bleeding	Mild	Moderate	Severe	_____
☐ ☐ Troublesome PMS symptoms	Mild	Moderate	Severe	_____
☐ ☐ Hot flashes/Night sweats	Mild	Moderate	Severe	_____
☐ ☐ Painful intercourse/sexual concerns	Mild	Moderate	Severe	_____

Are you currently using any method of birth control? ☐Yes ☐No Any concerns? _____

☐ Pill/Patch/Vaginal Ring ☐ Depo-Provera Shot ☐ IUD ☐ Nexplanon ☐ Not Sexually Active

☐ Tubal Ligation/Vasectomy ☐ Condoms ☐ Diaphragm ☐ Natural Family Planning ☐ Attempting Pregnancy

OBSTETRIC HISTORY:

Pregnancies _____ # Deliveries _____ # Miscarriages _____ # Abortions _____ # Ectopic _____

Pregnancies: (Outcome is Vaginal, C-section, Miscarriage, Abortion or Ectopic)					**Child**			
Date	Gestational Weeks	Outcome	Epidural	Complications	Sex	Weight	Name	Living
/ /			☐Yes ☐No		☐F ☐M			☐Yes ☐No
/ /			☐Yes ☐No		☐F ☐M			☐Yes ☐No
/ /			☐Yes ☐No		☐F ☐M			☐Yes ☐No
/ /			☐Yes ☐No		☐F ☐M			☐Yes ☐No

PROVIDENCE
Medical Group
Women's Services

PATIENT LABEL

PAST OR CURRENT MEDICAL PROBLEMS: (Please check if YOU have or have ever had):

Yes	No		Yes	No	
☐	☐	Anemia	☐	☐	Kidney / Urinary issues (e.g. frequent UTIs)
☐	☐	Asthma/Allergies	☐	☐	Liver Disease / Hepatitis B or C
☐	☐	Arthritis / Bone / Muscle / Joint problems	☐	☐	Lupus / Rheumatoid arthritis
☐	☐	Breast problems or surgeries	☐	☐	Mental health concerns (e.g. anxiety/depression/bipolar/other)
☐	☐	Cancer	☐	☐	Migraines/Migraines with aura
☐	☐	Diabetes or history of gestational diabetes	☐	☐	PCOS
☐	☐	Digestive / Stomach problems	☐	☐	Seizures
☐	☐	Heart problems	☐	☐	Skin Issues/Concerns
☐	☐	HIV/AIDS	☐	☐	STDs (e.g. gonorrhea/chlamydia/syphilis/genital herpes/other)
☐	☐	High blood pressure	☐	☐	Stroke
☐	☐	History of blood clots in legs or lungs	☐	☐	Thyroid disease
☐	☐	Infertility	☐	☐	Trauma/Violence

*If **YES**, please describe and list any other health concerns*_____

_____

SURGERIES AND/OR HOSPITALIZATIONS AND APPROXIMATE DATES (Month/Year):

Surgery	Date	Surgery	Date
_____		_____	
_____		_____	
_____		_____	

FAMILY HISTORY: Has anyone in your family had:

Breast cancer_____ Uterine, Cervical or Ovarian Cancer_____

Colon cancer _____ High blood pressure_____

Heart disease _____ Diabetes _____

Thyroid disorders_____ Preterm labor/ miscarriages etc. _____

Other significant family health concerns? _____

SOCIAL HISTORY/HABITS:

Are you currently in recovery for alcohol or substance use? ☐ Yes ☐ No

How many times in the past year have you had 4 or more drinks in a day? ☐ Never ☐ 1 or more

O*ne drink = 12oz beer, 5oz wine, 1.5oz liquor (one shot)*

How many times in the past year have you used a recreational drug OR used a prescription medication for nonmedical reasons? ☐ Never ☐ 1 or more ***Recreational Drugs*** *include methamphetamines, cannabis (marijuana/pot), inhalants (aerosols, glue), tranquilizers (Valium), barbiturates, cocaine, ecstasy, hallucinogens (LSD, mushrooms), or narcotics (heroin).*

Which statement best describes your **smoking status**?

☐ Never smoked ☐ Prior Smoker: Year quit: _____ ☐ Current Smoker: Packs / amount per day _____

Do you use vaping products? ☐ Yes ☐ No

Do you feel safe in your current relationship? ☐ Yes ☐ No

Exercise Habits: Do you exercise? ☐ Never ☐ Occasionally ☐ Regularly; Type? _____

Nutrition or weight concerns you would like to address? ☐ Yes ☐ No; Describe: _____

*EMR Entry by*_____