Galen OBGYN Ridgeside Patient Intake Form

For Office Use Only

Name: _____ Today's Date: _____

Date of Birth:_____ Age: _____

Primary Care Physician: _____

*BP:*_____ *Height:* _____

Pulse: _____ *Weight:*_____

Temp: _____ *LMP:*_____

Reason for Visit Today: (Problems during a wellness exam are subject to an additional charge. This additional charge may result in a copay/coinsurance/deductible payment due. Some insurance companies require a separate visit for problems. You may be asked to return for the problem)

☐ Wellness Exam ☐ Wellness Exam with Problems (Please List)_____

☐ Other: _____

Can we leave test/lab results or appointment information on your voice mail or answering machine? ☐ Yes ☐ No

Patient History

Menstrual History:

Age of 1st Period: _____ # of Days between Periods _____

# of Days Periods last: _____ Flow: ☐ Light ☐ Medium ☐ Heavy

Use: ☐ Tampons or ☐ Pads # Used per Day: _____

Date of Last Period: _____ Certainty of LMP Date: _____%

Do you have sex with: ☐ Men ☐ Women ☐ Both ☐ Not Sexually Active

Pregnancy Prevention**:** ☐ Pills ☐ Condoms ☐ Depo Provera ☐ IUD ☐ Nexplanon ☐ Surgical Sterilization ☐ Partner Vasectomy ☐None If birth control pills, list medication: _____

Menopause Status: ☐Premenopausal ☐Perimenopausal ☐Postmenopausal Age Onset: _____

Pregnancy History:

# of Pregnancies: _____ # Full Term: _____ # Premature: _____ # Miscarriage: _____ # Abortions: _____ # Ectopics:_____

# of Vaginal Deliveries: _____ # of C-Sections: _____

Date of Delivery	Total Weeks Pregnant	Hours Labor	Birth Weight	Sex	Type of Delivery	Method of Anesthesia	Early Labor	Complications	Location of Delivery

Details regarding pregnancies you feel the doctor should know:

Patient Medical History – *Please check all that apply and list medication to treat condition:*

Condition:	**Medication(s) with dosage:**
☐ Arthrits _____	_____
☐ Asthma _____	_____
☐ Bleeding tendency_____	_____
☐ Cancer _____	_____
☐ Diabetes_____	_____
☐ Depression/anxiety/mental illness_____	_____
☐ Heart trouble _____	_____
☐ Hepatitis _____	_____
☐ HIV/AIDS _____	_____
☐ High blood pressure _____	_____
☐ Hormone replacement therapy _____	_____
☐ Stroke/deep vein thrombosis_____	_____
☐ Seizures _____	_____
☐ Sexually transmitted disease _____	_____
☐ Thyroid disorder _____	_____
☐ Other_____ _	_____
☐ Other _____	_____

Please list any past medical conditions not listed above:

Allergies: _____

Past Surgical History: *Please list all previous surgeries/serious injuries including dates*

Hysterectomy: ☐ Abdominal ☐ Laparoscopic ☐Robotic ☐ Vaginal _____
Ovaries Removed? ☐ Both ☐ Left ☐Right

_____ **Date:** _____

_____ **Date:** _____

_____ **Date:** _____

Preventative Screening/Immunizations - *Please select all that apply and date performed/given:*

☐ Cervical Cancer Screening (Pap Smear):_____ ☐ Flu Vaccination: _____

☐ Mammogram: _____ ☐ HPV (Gardisail Vaccination) ☐ Series 1 ☐ Series 2 ☐ Series 3

☐ Colonoscopy _____

☐ Bone Density: _____ ☐ TDap Vaccination _____

Do you perform monthly breast exams: ☐ Yes ☐ No

Social History – *Please Circle One*:

Marital Status:	Single	Married	Separated	Divorced	Widowed
Use of Alcohol:	Never	Rarely	Moderate	Daily	
Use of Tobacco:	Never	Quit	Current packs/day: _____		
Use of Drugs:	Never	Type/Frequency: _____			

Has anyone close to you ever threatened to hurt you: ☐ Yes ☐ No

Has anyone ever hit, kicked, choked, or hurt you physically: ☐ Yes ☐ No

Has anyone, including your partner, ever forced you to have sex: ☐ Yes ☐ No

Are you ever afraid of your partner: ☐ Yes ☐ No

High Risk Assessment Critera - *Please check all that apply:*

☐ Vaginosis ☐ Genital Warts ☐ Chlamydia ☐ Gonorrhea ☐Trichomonas ☐Syphilis

Have you had a Pap smear in the last 7 years: ☐ Yes ☐ No

Have you ever had an abnomal pap test: ☐ Yes ☐ No

Did you begin sexual activity before you were 16 years old: ☐ Yes ☐ No

Have you had more than 5 sexual partners in your lifetime: ☐ Yes ☐ No

Have you ever tested positive for HIV virus: ☐ Yes ☐ No

Did your mother take the drug DES when she was pregnant with you: ☐ Yes ☐ No

Family History - Please Check All That Apply**:**

Disease	Mother	Father	Brother	Sister	Son	Daughter	Grand mother*	Grand father*	Aunt*	Uncle*
Pancreatic Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Breast Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Colon Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Cystic Fibrosis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Depression/Mental Illness	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Genetic Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Kidney Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Ovarian Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Thyroid Disorder	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Uterine Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other Please list below:										

*Please put an "M" for Mother's side and "F" for Father's side. Only on Grandparents, Aunt, and Uncle.

REVIEW OF SYSTEMS

Please check all symptoms that apply:

Constitutional Symptoms
- Good general health lately ☐
- Fever ☐
- Chills ☐
- Fatigue ☐
- Recent weight loss ☐
- Recent weight gain ☐

Eyes
- Change in vision ☐
- Double vision ☐
- Loss of vision ☐
- Pain ☐
- Tearing ☐
- Impaired vision (glasses/contacts) ☐
- Peripheral vision changes ☐
- Glaucoma ☐

Ears/Nose/Throat
- Nose bleeds ☐
- Hoarseness ☐
- Decreased Hearing ☐
- Mass ☐
- Pain ☐

Endocrine
- Excessive Thirst ☐
- Excessive Urination ☐
- Heat intolerance ☐
- Cold intolerance ☐
- Hair Thinning ☐
- Hot Flashes ☐
- Night Sweat ☐

Respiratory
- Shortness of breath ☐
- Asthma or wheezing ☐
- Chronic or frequent coughs ☐

Breast
- Change ☐
- Tenderness ☐
- Pain ☐
- Discharge ☐
- Lumps ☐
- Identation ☐

Cardiovascular
- Chest pain ☐
- Swelling of feet, ankles or hands ☐
- Palpitations ☐
- Racing Heart ☐

Gastrointestinal
- Abdominal pain ☐
- Nausea ☐
- Vomiting ☐
- Diarrhea ☐
- Constipation ☐
- Blood with bowel movement ☐

Blood and Lymph
- Easy bruising ☐
- Enlarged glands/lymph nodes ☐
- Anemia ☐
- Blood Problems ☐

Urinary and Reproductive
- Frequent urination ☐
- Urgency to urinate ☐
- Pain with urination ☐
- Leaking at Night ☐
- Blood in urine ☐
- Heavy periods ☐
- Irregular periods ☐
- Periods stopped ☐
- Hot flashes/night sweats ☐
- Unusual vaginal discharge ☐
- Vagnial Itching ☐
- Vaginal dryness ☐
- Breakthrough Bleeding ☐
- Lack of sexual desire ☐
- Painful intercourse ☐
- Painful Period ☐

Musculoskeletal
- Joint pain ☐
- Joint swelling ☐
- Join Deformity ☐
- Muscle cramps ☐
- Mucle spasms ☐
- Back pain ☐

Integument (Skin)
- Recent changes to skin ☐
- Rash ☐
- Lesion ☐
- Mole ☐
- Change in mole or lesion ☐
- Facial Hair ☐
- Acne ☐

Neurological
- Frequent headaches ☐
- Inability to move arm/legs ☐
- Tingling or numbness ☐
- Weakness ☐
- Light headed or dizzy ☐

Psychiatric
- Depression ☐
- Anxiety ☐
- Difficulty sleeping ☐
- Suicidial or homicidal thoughts ☐
- Eating Disorder ☐