CAPE GYNECOLOGY

INTAKE HISTORY

NAME:_____ BIRTH DATE:____/____/_____ DATE:____/____/____

ADDRESS:_____

CITY_____ STATE/ZIP:_____

HOME TEL:( )_____ WORK TEL:( ) _____

EMPLOYER:_____ INSURANCE:_____

NAME OF SPOUSE/PARTNER:_____ REFERRED BY:_____

REVIEW OF SYSTEMS

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

1. CONSTITUTIONAL	CURRENTLY	PAST	NOTES
Weight loss	☐	☐	
Weight gain	☐	☐	
Fever	☐	☐	
Fatigue	☐	☐	
2. EYES			
Double vision	☐	☐	
Spots before eyes	☐	☐	
Vision changes	☐	☐	
3. ENT/MOUTH			
Ear aches	☐	☐	
Ringing in ears	☐	☐	
Sinus problems	☐	☐	
Sore throat	☐	☐	
Mouth sores	☐	☐	
Dental problems	☐	☐	
4. CARDIOVASCULAR			
Painful breathing	☐	☐	
Chest pain	☐	☐	
Difficult breathing on exertion	☐	☐	
Swelling of legs	☐	☐	
Palpitations of heart	☐	☐	
5. RESPIRATORY			
Wheezing	☐	☐	
Shortness of breath	☐	☐	
Cough, chronic	☐	☐	
6. GASTROINTESTINAL			
Diarrhea, frequent	☐	☐	
Bloody stool	☐	☐	
Nausea/vomiting	☐	☐	
Constipation	☐	☐	
7. GENITOURINARY			
Blood in urine	☐	☐	
Pain with urination	☐	☐	
Urgency	☐	☐	
Frequency of urination	☐	☐	
Incomplete emptying	☐	☐9	
Stress incontinence	☐	☐	
Abnormal periods	☐	☐	–
Painful intercourse	☐	☐	
Pelvic pain	☐	☐	

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

8. MUSCULOSKELETAL			
Muscle weakness	☐	☐	
9. SKIN/BREAST	**CURRENTLY**	**PAST**	**NOTES**
Pain in breast	☐	☐	
Discharge	☐	☐	
Masses	☐	☐	
Rash	☐	☐	
Ulcers	☐	☐	
10. NEUROLOGICAL			
Dizziness	☐	☐	
Seizures	☐	☐	
Numbness	☐	☐	
Trouble walking	☐	☐	_
11. PSYCHIATRIC			
Depression	☐	☐	
Crying, frequent	☐	☐	
12. ENDOCRINE			
Dry skin	☐	☐	
Abnormal thirst	☐	☐	
Hot flashes	☐	☐	
13. HEMATOLOGIC/LYMPHATIC			
Bruises, frequent	☐	☐	
Cuts do not stop bleeding	☐	☐	-
Enlarged lymph nodes	☐	☐	
14. ALLERGIC/IMMUNOLOGIC			
Allergies-environmental	☐	☐	
Medication, etc (please list)	☐	☐	

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		
Sexually transmitted infections			Bowel trouble		
Heart Trouble/murmur			Glaucoma		
Diabetes			Arthritis/joint pain		
High Blood Pressure			Fracture		
Stroke			Hepatitis/Yellow jaundice		
Rheumatic Fever			Thyroid Disease		

OPERATIONS/HOSPITALIZATIONS

Reason	Date	Reason	Date

INJURIES/ILLNESSES

Type	Date	Type	Date

LAST IMMUNIZATION OR TEST

	Date		Date
Tetanus		Pneumonia	
Flu Shot		Gardasil/HPV	

OB/GYN HISTORY

	Number		Number
Births		Abortions	
Miscarriages		Living children	

Last Pap Smear Date:	Any Abnormal Paps?
Last Menstrual Period Date:	Last Mammography Date:
Last Bone Density Date:	Last Colonoscopy Date:

FAMILY HISTORY

illness	Yes	Relative	Illness	Yes	Relative
Diabetes			Drinking Problem		
Stroke			Breast Cancer		
Heart Disease			Colon Cancer		
High Blood Pressure			Ovarian Cancer		

SOCIAL HISTORY

Habits						
Sunscreen Use	Yes ☐	No ☐				
Smoking	Yes ☐	No ☐	Packs per day_____	Years_____		
Alcohol	Yes ☐	No ☐	Drinks per day_____	Drinks per week_____		
Drug Use	Yes ☐	No ☐				
Seat Belt Use	Yes ☐	No ☐				
Regular Exercise	Yes ☐	No ☐				

Personal Profile				
Marital Status	Married ☐	Single ☐	Widowed ☐	Divorced ☐
Number of Living Children_____				
Number of people in household_____				
School Completed	High School ☐	College ☐	Graduate Degree ☐	Other ☐
Current or most recent job_____				

Completed by: Patient ☐ Office Nurse ☐ Physician ☐

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:_____

Date reviewed:_____ Physician Signature:_____

CURRENT MEDICATIONS

DRUG NAME	DOSE

REVIEWED BY: _____ **DATE:** _____

_____ _____

_____ _____

_____ _____