Renée C. Smith M.D., FACOG
Wise Obstetrics & Gynecology, P.A.

Name: ___________________________________

GYNECOLOGIC INTAKE HISTORY

Please check the appropriate box if any of the following apply to you now or have applied in the past

CONSTITUTIONAL	**Currently**	**Past**	**Notes**
Weight Loss			
Weight Gain			
Fever			
Fatigue			
EYES			
Double Vision			
Spots before Eyes			
Vision Changes			
ENT / MOUTH			
Ear Aches			
Ringing in Ears			
Sinus Problems			
Sore Throat			
Mouth Sores			
Dental Problems			
CARDIOVASCULAR			
Painful Breathing			
Chest Pain			
Difficulty Breathing on Exertion			
Swelling of Legs			
Palpitations of Heart			
RESPIRATORY			
Wheezing			
Spitting up Blood			
Shortness of Breath			
Chronic Chough			
GASTROINTESINTAL			
Frequent Diarrhea			
Blood in Stool			
Nausea / Vomiting			
Constipation			
GENITOURINARY			
Blood in Urine			
Pain with Urination			
Urgency			
Frequency of Urination			
Incomplete Emptying			
Stress Incontinence			
Abnormal Periods			
Painful Intercourse			
MUSCULOSKETAL			
Muscle Weakness			
SKIN / BREAST			
Pain in Breast			
Discharge			
Masses			
Rash			
Ulcers			

NEUROLOGICAL	Currently	Past	Notes
Dizziness			
Seizures			
Numbness			
Trouble Walking			
PSYCHIATRIC			
Depression			
Frequent Crying			
ENDOCRINE			
Dry Skin			
Abnormal Thirst			
Hot Flashes			
HEMOTOLOGIC / LYMPHATIC			
Frequent Bruising			
Cuts that don't stop bleeding			

LAST IMMUNIZATION OR TEST

Tetanus/Flu Shot	Date	TB Skin Test	Pneumonia	Date

PERSONAL SAFETY	Yes	No
Has anyone close to you ever threatened to hurt you?		
Has anyone ever hit, kicked, choked or hurt you physically?		
Has anyone, including your partner, ever forced you to have sex?		
Are you afraid of your partner?		
Please check if you have been treated for any of the following infections: ❑ Vaginosis ❑ Genital Warts ❑ Chlamydia ❑ Trichomoniasis ❑ Gonorrhea ❑ Syphilis		
	Yes	No
Have you had a Pap Smear in the last 7 years?		
Have you ever had an abnormal Pap Smear test?		
Did you begin sexual activity before you were 16 years old?		
Have you had more than 5 sexual partners in your lifetime?		
Have you ever tested positive for the HIV virus?		
Did your mother take the drug DES when she was pregnant with you?		

Completed by: ❑ Patient ❑ Office Nurse ❑ Physician

Signature of Patient: ______________________________________

Date Reviewed by Physician with Patient ___________________

Physician Signature _______________________________________