LIFEBRIDGE HEALTH
CARE BRAVELY

Obstetrics and Gynecology Patient Health History - Intake Form

Patient Information

Name:_____ Today's Date:_____

Name on legal documents (if different):_____

What pronouns do you use?(please circle) she/her he/him they/them other:_____

Date of Birth:_____ Address:_____

Cell Phone #:_____ Home Phone #:_____

Who may we contact in case of emergency?

Name:_____ Relationship:_____

Phone#:_____

Are you: ☐ Married ☐ Partnered/in a committed relationship ☐ Divorced

☐ Legally Separated ☐ Widowed ☐ Single

Are you allergic to any medications? ☐ Yes ☐ No (If yes, please list below)

_____

Past Medical History

If you have ever had a listed condition in the past/present, please indicate below.

PAST	PRESENT	CONDITION	PAST	PRESENT	CONDITION
☐	☐	Alcohol/substance abuse	☐	☐	Heart Attack/Disease
☐	☐	Anemia	☐	☐	Heartburn/Indigestion
☐	☐	Anorexia/bulimia	☐	☐	Heart Failure
☐	☐	Anxiety	☐	☐	Hemorrhoids
☐	☐	Aortic Aneurysm	☐	☐	Hepatitis
☐	☐	Arthritis	☐	☐	High Blood Pressure
☐	☐	Asthma	☐	☐	Kidney Disease
☐	☐	Bleeding Disorder (DVT/PE)	☐	☐	Kidney Stones
☐	☐	Cancer (type:_____)	☐	☐	Low Back Pain
☐	☐	Colitis/ulcers/ Crohn's	☐	☐	Palpitations (Rapid Heart Beat)
☐	☐	Convulsions/Seizures/Epilepsy	☐	☐	Pneumonia
☐	☐	Cysts	☐	☐	Rheumatoid Arthritis
☐	☐	Diabetes	☐	☐	Sexually Transmitted Infections
☐	☐	Depression	☐	☐	Stroke (Date:_____)
☐	☐	Emphysema/COPD	☐	☐	Visual or hearing impairment
☐	☐	Endometriosis	☐	☐	Thyroid Condition
☐	☐	Fibroids	☐	☐	Tuberculosis
☐	☐	Gallstones/ gall bladder disease	☐	☐	Other:_____
☐	☐	Headaches/migraines			

Social History

Do you drink alcohol? ☐ Yes ☐ No If yes, how many drinks per day?_____

Do you smoke? ☐ Yes ☐ No If yes, how many cigarettes per day?_____

If yes, how many years have you smoked?_____

Do you use chewing tobacco? ☐ Yes ☐ No

Do you use smokeless tobacco (Vape)? ☐ Yes ☐ No Specify:_____

Do you drink caffeine? ☐ Yes ☐ No If yes, how many cups per day?_____

Do you use any recreational drugs? ☐ Yes ☐ No

If yes, please list (including marijuana):_____

If yes, how? ☐ Intravenous ☐ Snort/inhale ☐ Vape

Gynecological & Obstetrical History

Age of onset periods:_____ Frequency:_____ Length of bleeding:_____

Date of last menstrual period:_____ # of pregnancies:_____ # of births:_____

# of miscarriages or abortions:_____ # of Full Term Births:_____ # of Preterm Births_____

Living Children:	Month/ Year of Delivery	Type of Delivery (Vaginal/C-Section)
	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_____	_____

Have you had any pregnancy complications? (High blood pressure, preterm labor, diabetes, etc.)

☐ Yes ☐ No If yes , please list: _____

What form of birth control do you use? _____

Would you like to discuss birth control today? Yes No

Have you or are you currently experiencing:

Prolonged or Abnormal bleeding	☐ Yes	☐ No
Leakage of urine	☐ Yes	☐ No
Pelvic pain	☐ Yes	☐ No
Abnormal discharge	☐ Yes	☐ No
History of abnormal PAP smear	☐ Yes	☐ No
Vaginal Dryness	☐ Yes	☐ No
Symptoms of Prolapse	☐ Yes	☐ No
Hot flashes	☐ Yes	☐ No

If yes: Has the pain lasted more than 6 months? ☐ Yes ☐ No

Do you have the pain during your menstrual cycle? ☐ Yes ☐ No

Sexual History

Are you currently sexually active? ☐ Yes ☐ No

If yes; # of partners in the last year_____

Have you ever been sexually active with:

Men	☐ Yes	☐ No	If yes:	☐ Currently	☐ Past
Women	☐ Yes	☐ No	If yes:	☐ Currently	☐ Past
Transgender Men	☐ Yes	☐ No	If yes:	☐ Currently	☐ Past
Transgender Women	☐ Yes	☐ No	If yes:	☐ Currently	☐ Past

What types of sexual practices do you engage in?

Vaginal	☐ Give	☐ Receive
Anal	☐ Give	☐ Receive
Oral	☐ Give	☐ Receive

Do you have pain after sex?	☐ Yes	☐ No		
Do you have bleeding after sex?	☐ Yes	☐ No		
How often do you practice safe sex?	☐ Always	☐ Sometimes	☐ Rarely	☐ Never
What methods are used for safe sex?	☐ Condoms	☐ Gloves	☐ Dental Dams	☐ Other: _____
Do you take or have you taken PrEP or post exposure prophylaxis?	☐ Yes	☐ No		
Would you like more information on safer sex practices?	☐ Yes	☐ No		
Would you like to be screened for Sexually Transmitted Infections?	☐ Yes	☐ No		

Preventative

Health Service	Date		Date
Breast exam	_____	Mammogram	_____
Colonoscopy	_____	Pap Smear	_____
Cholesterol check	_____	Prostate exam (if applicable)	_____
DEXA Scan (Bone Scan)	_____	Stool Check for blood	_____
General Physical by PCP	_____		

Immunization History - Have you had any of the following?

Vaccine			Date
Flu Vaccine	☐ Yes	☐ No	_____
Gardasil (HPV Vaccine)	☐ Yes	☐ No	_____
Hepatitis B	☐ Yes	☐ No	_____
Measles, Mumps, Rubella	☐ Yes	☐ No	_____
Pneunovax	☐ Yes	☐ No	_____
Tetanus (TDAP)	☐ Yes	☐ No	_____
Varicella	☐ Yes	☐ No	_____

Do you wear a seatbelt?	☐ Always	☐ Sometimes	☐ Never
Do you wear a bike helmet?	☐ Always	☐ Sometimes	☐ Never
Do you have a gun in your home?	☐ Yes	☐ No	
If yes: Is it loaded?	☐ Yes	☐ No	
If yes: Is it out of a child's reach?	☐ Yes	☐ No	
Have you ever worked with chemical, asbestos or other hazardous materials?	☐ Yes	☐ No	
Have you experienced Intimate Partner Violence?	☐ Yes	☐ No	
Do you feel safe in your home?	☐ Yes	☐ No	
Do you have a living will?	☐ Yes	☐ No	
Do you have Advance Directives?	☐ Yes	☐ No	
Are you a registered organ donor?	☐ Yes	☐ No	

Previous Surgeries

☐ I have **NEVER** had any surgical procedures.

Surgery	Year
_____	_____
_____	_____
_____	_____
_____	_____

Please list hospitalizations other than for surgery or childbirth below:

_____

_____

_____

_____

_____

_____

Family History

Disease	Family Member	Age of Diagnosis
☐ Cancer (*type*_____)	_____	_____
☐ Cancer (*type* _____)	_____	_____
☐ Hypertension	_____	_____
☐ Kidney Problems	_____	_____
☐ Glaucoma	_____	_____
☐ Diabetes	_____	_____
☐ Drug or alcohol addiction	_____	_____
☐ Heart Disease	_____	_____
☐ Stroke	_____	_____
☐ High Blood Pressure	_____	_____
☐ Bleeding Disease *(Deep Vein thrombosis/ Pulmonary Embolism)*	_____	_____
☐ Mental Illness *(Anxiety, depression, etc.)*	_____	_____
☐ Other:	_____	_____
☐ Other:	_____	_____

Are you taking any medications currently?

☐ I am **NOT** currently taking any medications

Current Medications, Names and Dose:

Name:_____ Dose:_____

Name:_____ Dose:_____

Name:_____ Dose:_____

Name:_____ Dose:_____

Name:_____ Dose:_____

Name:_____ Dose:_____

Name:_____ Dose:_____

Are you taking any Vitamins/ Minerals/ Herbs? ☐ Yes ☐ No

Name:_____ Dose:_____

Name:_____ Dose:_____

Name:_____ Dose:_____

Patient Signature