GYNECOLOGY INTAKE FORM

Date of visit:		
PATIENT INFORMATION		
Last Name:	First Name:	Middle Initial:
Street Address:	City:	
Postal Code:	Home phone number:	Daytime phone number:
May we leave messages relating to your visits: ☐ Yes ☐ No	Email:	
Date of Birth: (MM/DD/YYYY)		
EMERGENCY CONTACT INFORMATION		
1. Last Name:	First Name:	Relationship:
Daytime phone number:	Evening phone number:	
2. Last Name:	First Name:	Relationship:
Daytime phone number:	Evening phone number:	
OTHER HEALTH CARE PROVIDERS		
1. Name:	2. Name:	3. Name:

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Phone number:	Phone number:	Phone number:
Specialty/focus:	Specialty/focus:	Specialty/focus:

Date of last visit to medical doctor:	Date of most recent PAP test:
Are you currently under his/her care? ☐ Yes ☐ No	Date of most recent breast exam:
Are you currently under the care of a Naturopathic Doctor? ☐ Yes ☐ No	Do you do self breast examinations? ☐ Yes ☐ No

WELLNESS HISTORY QUESTIONNAIRE

The following questions are to help me determine your risk factors for various gynecological conditions and to help me to conduct the examination with sensitivity. All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Have you received the HPV vaccination? ☐ Yes ☐ No

Have you taken or are you currently taking oral contraceptives? ☐ Yes ☐ No

If yes, please describe number of years, and type of oral contraception:

Have you used or are currently using any other form of contraception? ☐ Yes ☐ No

If so, please list with appropriate time frame:

Have you ever been diagnosed with any Sexually Transmitted Infections (including genital warts, Chlamydia, gonorrhea, etc..)? ☐ Yes ☐ No

If yes, please describe:	
Age of first sexual intercourse:	Number of lifetime sexual partners:
History of abnormal PAP? ☐ Yes ☐ No	Do you currently smoke? ☐ Yes ☐ No
Number of pregnancies:	Number of live births:
Do you have a family history of cervical dysplasia? ☐ Yes ☐ No	
Are you currently sexually active? ☐ Yes ☐ No If so, are you currently sexually active with: ☐ Men ☐ Women	
List any medical conditions that other health care practitioners have diagnosed:	

Year:	Condition:

List your prescribed drugs, over-the-counter medications and supplements, (pain killers, vitamins, herbs, homeopathics, etc…

Medication	Dosage/day	Date started

Please list all allergies (medications, foods, supplements, environmental, etc…)

Name of allergen:	Reaction you had:

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Please use this space to write down any other questions or concerns you would like to discuss during your visit:	

PLEASE NOTE: If you are menstruating heavily, please call to reschedule your examination. Light bleeding (requiring 1-2 pads/tampons per day) do not need to be rescheduled.

Please refrain from sexual intercourse 24 hours prior to visit, and please refrain from vaginal applications of any kind as well as douching for 48 hours prior to your examination.