BAYSIDE WOMEN'S HEALTH
ANNUAL MEDICAL INTAKE FORM

Patient Name: _____ **Chart #:** _____ **Date:** _____

To help your doctor during today's health exam, please complete items 1 through 16.

1. Age: _____ Marital Status: S M D W SEP.

When was the ***FIRST DAY*** of your last period? _____

What method of birth control do you use? _____

2. Number of times you have been pregnant: _____

Number of living children: _____

Are you planning a pregnancy in the next 6-12 months? YES NO

3. When was your last Pap Test? _____

Have you ever had an Abnormal Pap*?* YES NO

***If yes, When?* _____

Did you have any of the following?

Colpo/Biopsies	YES	NO
LEEP/CRYO	YES	NO
Surgery	YES	NO

4. Do you have any of the following:

A. Problems with present method of birth control	YES	NO
B. Bleeding between periods	YES	NO
C. Pain with sex	YES	NO
D. Any problem with interest in or enjoying sex	YES	NO
E. A new or enlarging lump in breast	YES	NO
F. Change in size/firmness of stool	YES	NO
G. Blood clots (leg, lung, etc.)	YES	NO
H. Headaches	YES	NO
I. Pain in joints	YES	NO
J. Pain in chest	YES	NO
K. Pain in abdomen	YES	NO
L. Trouble falling or staying asleep	YES	NO
M. Often feeling down, depressed or hopeless in the past month	YES	NO
N. Often having little/no interest in hobbies/daily activities during the past month	YES	NO
O. Is conflict in your family or relationships, sometimes handled by pushing, hitting, or cruelty?	YES	NO
P. High blood pressure	YES	NO

5. Do you have a parent, grandparent, brother or sister with history of the following:

A. Cancer	YES	NO
B. Heart attacks	YES	NO
C. High Blood Pressure	YES	NO
D. Diabetes	YES	NO

***If yes to any of the above please list them below:*

Relation: _____ Type: _____

Relation: _____ Type: _____

Relation: _____ Type: _____

Relation: _____ Type: _____

6. Have you ***EVER*** used tobacco? YES NO

***If yes, please continue below:*

A. Number of packs/day: _____

B. Number of years smoked: _____

C. Year quit: _____

7. Do you drink alcohol? YES NO

***If yes, please continue below:*

A. How much? (OCC) (MOD) (HEAVILY)

B. Have you ever felt you should decrease your drinking? YES NO

C. Has anyone ever seemed concerned about your drinking? YES NO

D. Have you ever felt guilty about your drinking? YES NO

8. Do you drink caffeine? YES NO

***If yes how much?* _____ *(Cups per day)*

9. Do you currently use illegal drugs? YES NO

10. Which of the following are included in your diet:

Grains/Starches	a lot	some	none
Vegetables	a lot	some	none
Dairy	a lot	some	none
Meats	a lot	some	none
Sweets	a lot	some	none

11. Do you exercise regularly? _____

Activity: _____

Days per week: _____

12. Have you had your cholesterol level checked? YES NO

13. Have you ever had a colonoscopy? YES NO

***If yes, when:* _____

14. Have you ever had a mammogram? YES NO

***If yes, when:* _____

Have you ever had an abnormal mammogram? YES NO

***If yes, when:* _____

15. If you are 65 or older have you ever had a bone density scan? YES NO

***If yes, when:* _____

16. Please describe any problems you are currently having:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____