UB|MD OBSTETRICS & GYNECOLOGY

Annual Intake Return Form

Today's Date: _______________

Name: ____ Date of Birth: ________________

Referring Physician: __________________________________ Primary Care Physician: ________________________________

Reason for Today's visit: ____

GYNECOLOGIC HISTORY: Check if you have had any of the following:

☐ Chlamydia
☐ Gonorrhea
☐ Herpes
☐ HIV
☐ HPV/genital warts
☐ Syphilis
☐ Trichomonas
☐ Pelvic inflammatory disease
☐ Uterine fibroids
☐ Pain with sex
☐ Ovarian cyst
☐ Chronic pelvic pain
☐ Premenstrual syndrome (PMS)
☐ Infertility
☐ Urinary incontinence
☐ Endometriosis
☐ Abnormal uterine structure
☐ Yeast
☐ Bacterial vaginosis (BV)
☐ Abnormal Pap test
☐ Recurrent vaginitis
☐ Vaginal dysplasia (pre-cancer)
☐ Vulvar dysplasia (pre-cancer)
☐ Vulvar pain
☐ Other: ___________________

Last Menstrual Period:_______________

MEDICAL HISTORY: Have there been any changes? Check all that apply:

☐ None
☐ Diabetes
☐ Hypertension (High blood pressure)
☐ Asthma
☐ Cancer (type) __________________
☐ Depression
☐ Elevated Cholesterol
☐ Fibroids
☐ Heart disease
☐ Sleep Apnea
☐ Migraines
☐ Osteopenia
☐ Osteoporosis
☐ Other, please specify
____

Last Pap smear: ________________ was it abnormal? ☐ NO ☐ YES if yes, explain: ___________________________

Last Mammogram: ________________ was it abnormal? ☐ NO ☐ YES if yes, explain: ___________________________

Last Colonoscopy: ________________ was it abnormal? ☐ NO ☐ YES if yes, explain: ___________________________

SEXUAL HISTORY:

Are you sexually active? ☐ NO ☐ YES Have you ever been sexually active? ☐ NO ☐ YES

Have your partner (s) in the past/present been ☐ MALE ☐ FEMALE ☐ BOTH

Do you have concerns about sexually transmitted infections? ☐ NO ☐ YES ☐ UNSURE

Do you or your partner have more than one partner? ☐ NO ☐ YES

What method of birth control, if any, are you using? ____

What birth control, if any, have you used in the past? ____

(PLEASE TURN OVER AND COMPLETE BACK)

SURGICAL HISTORY:

Have there been any changes to your Surgical History? ☐ NO ☐ YES

- No
- Yes , list procedure, year and hospital

____

____

FAMILY HISTORY:

Have there been any changes to your Family History? ☐ NO ☐ YES if yes, please indicate below

ILLNESS	MOTHER	FATHER	SIBLING	MATERNAL GRANDMOTHER	PATERNAL GRANDMOTHER	MATERNAL GRANDFATHER	PATERNAL GRANDFATHER
Diabetes							
Heart Disease							
Cancer (type)							
Mental health disease							
Other: Specify							

Allergies (Medication and Environmental): ____

____

Current Medications (include all prescription, over the counter and topical medications):

Do you have changes to your current medications? ☐ NO ☐ YES if yes, please indicate below

Medication	Dose and Frequency	Condition

Pharmacy Name Address Telephone Number

____

_______________________________________ ____________________

Patient Signature Date

UB|MD Obstetrics & Gynecology

Review of Systems

Name: ______________________________________ Date: ________________

Please check all symptoms that you are currently experiencing:

Constitutional---------------------------
- ☐ Fever
- ☐ Chills
- ☐ Malaise
- ☐ Fatigue
- ☐ Anorexia
- ☐ Unintended weight gain

Head and Face---------------------------
- ☐ Facial Pain
- ☐ Facial Pressure

Eyes---
- ☐ Eye pain
- ☐ Red eyes
- ☐ Discharge from eyes
- ☐ Itchy eyes
- ☐ Blurred vision
- ☐ Vision changes
- ☐ Corrective lenses

ENT---
- ☐ Earache
- ☐ Loss of hearing
- ☐ Ringing ears
- ☐ Runny nose
- ☐ Nasal congestion
- ☐ Sore throat
- ☐ Scratchy throat
- ☐ Change in voice/hoarseness
- ☐ Dentures

Cardiovascular---------------------------
- ☐ Chest pain
- ☐ Racing heart
- ☐ Leg pain
- ☐ Leg swelling
- ☐ Lightheadedness/Fainting
- ☐ Poor exercise tolerance

Respiratory-------------------------------
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Sleeping upright/extra pillow
- ☐ Cough
- ☐ Dry cough
- ☐ Productive cough
- ☐ Clear sputum
- ☐ Colored sputum
- ☐ Vomiting blood
- ☐ Daytime sleepiness

Gastrointestinal-------------------------
- ☐ Decreased appetite
- ☐ Difficulty swallowing
- ☐ Esophageal reflux
- ☐ Abdominal pain
- ☐ Abdominal bloating
- ☐ Abdominal cramps
- ☐ Menstrual pain
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Unable to pass flatus
- ☐ Constipation
- ☐ Dark/bloody stools
- ☐ Rectal bleeding
- ☐ Change in color/size of stool
- ☐ Fecal incontinence

Genitourinary----------------------------
- ☐ Difficult/painful urination
- ☐ Loss of urine
- ☐ Urinary hesitancy
- ☐ Urinary urgency
- ☐ Frequent urination
- ☐ Night time urination
- ☐ Dark urine
- ☐ Blood in urine
- ☐ Flank pain
- ☐ Suprapubic pain
- ☐ Pelvic pain
- ☐ Foul-smelling vaginal discharge
- ☐ Heavy menstrual bleeding
- ☐ Painful menstrual cramps
- ☐ Missed menstrual period
- ☐ Suspected pregnancy
- ☐ Confirmed pregnancy
- ☐ Difficult/painful intercourse
- ☐ Postmenopausal bleeding

Musculoskeletal-------------------------
- ☐ Joint pain
- ☐ Joint swelling
- ☐ Joint stiffness
- ☐ Muscle pain
- ☐ Back pain
- ☐ Limping
- ☐ Falls

Skin/Breast-------------------------------
- ☐ Skin rash
- ☐ Itchy skin
- ☐ Skin wound/ulcer
- ☐ Skin lesions
- ☐ Mouth sores
- ☐ Redness
- ☐ Swelling
- ☐ Scaling
- ☐ Blisters
- ☐ Breast pain
- ☐ Breast lump
- ☐ Nipple discharge

Neurologic--------------------------------
- ☐ Frequent headaches
- ☐ Migraines
- ☐ Memory loss/confusion
- ☐ Dizziness
- ☐ Burning/prickling sensation
- ☐ Leg numbness
- ☐ Leg weakness
- ☐ Tingling
- ☐ Difficulty walking
- ☐ Vertigo
- ☐ Tremors

Psychiatric--------------------------------
- ☐ Insomnia
- ☐ Irritable
- ☐ Anxiety
- ☐ Depression
- ☐ Sleep disturbances
- ☐ Overwhelming stress
- ☐ Suicidal ideation

Endocrine---------------------------------
- ☐ Hot flashes
- ☐ Night sweats
- ☐ Heat/cold intolerance
- ☐ Abnormal thirst
- ☐ Decreased libido
- ☐ Excessive facial/chest/back hair
- ☐ Muscle weakness
- ☐ Generalized weakness

Hematology/Lymph--------------------
- ☐ Swollen lymph nodes
- ☐ Bleeding gums/Nose bleeds
- ☐ Easy bleeding
- ☐ Easy bruising
- ☐ Jaundice