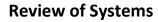


Annual Intake Return Form

Today's Date:					
Name:		Date of Birth: Primary Care Physician:			
Referring Physician:	Primary Care P				
Reason for Today's visit:					
GYNECOLOGIC HISTORY: Check if you have	ve had any of the following:				
□ Chlamydia	☐ Pain with sex	☐ Bacterial vaginosis (BV)			
□ Gonorrhea	□ Ovarian cyst	☐ Abnormal Pap test			
☐ Herpes	☐ Chronic pelvic pain	☐ Recurrent vaginitis			
□ HIV	□ Premenstrual syndrome (PMS)	Vaginal dysplasia (pre-cancer)			
☐ HPV/genital warts	□ Infertility	□ Vulvar dysplasia (pre-cancer)			
□ Syphilis	□ Urinary incontinence	□ Vulvar pain			
□ Trichomonas	□ Endometriosis	□ Other:			
☐ Pelvic inflammatory disease	☐ Abnormal uterine structure				
☐ Uterine fibroids	☐ Yeast				
Last Menstrual Period: MEDICAL HISTORY: Have there been any None	y changes? Check all that apply: ☐ Depression	□ Migraines			
□ Diabetes	☐ Elevated Cholesterol	□ Osteopenia			
☐ Hypertension (High blood pressure)	☐ Fibroids	□ Osteoporosis			
□ Asthma	☐ Heart disease	□ Other, please specify			
☐ Cancer (type)	☐ Sleep Apnea				
Last Pap smear:	was it abnormal? □ NO □ YES if y	es, explain:			
Last Mammogram:	was it abnormal? □ NO □ YES if y	res, explain:			
Last Colonoscopy:	was it abnormal? □ NO □ YES if y	res, explain:			
SEXUAL HISTORY:					
Are you sexually active? ☐ NO ☐ YES	Have you ever been sexu	ally active? □ NO □ YES			
Have your partner (s) in the past/preser	nt been	ТН			
Do you have concerns about sexually tra	ansmitted infections? □ NO □ YES	□UNSURE			
Do you or your partner have more than	·				
What method of birth control, if any, ar	e you using?				
What birth control, if any, have you use	d in the past?				

SURGICAL HISTO								
Have there be	en any changes	to your Surgio	al History?	□ NO □ YES				
o No								
 Yes , list procedure, year and hospital 								
FAMILY HISTORY	Y :							
Have there be	en any changes	to your Famil	/ History? \qed	NO □YES if yo	es, please indicat	e below		
ILLNESS	MOTHER	FATHER	SIBLING	MATERNAL GRANDMOTHER	PATERNAL GRANDMOTHER	MATERNAL GRANDFATHER	PATERNAL GRANDFATHER	
Diabetes								
Heart Disease								
Cancer (type)								
Mental health disease								
Other: Specify								
				unter and topical m				
	hanges to your				please indicate I	pelow		
Medication		Dose	and Frequer	ncy	Condition			
Pharmacy Name		Address		Telep	hone Number			
F	Patient Signatur	re				D	ate	





Na	me:		Date:							
Ple	Please check all symptoms that you are currently experiencing:									
Co	nstitutional	Gas	Gastrointestinal		Skin/Breast					
	Fever		Decreased appetite		Skin rash					
	Chills		Difficulty swallowing		Itchy skin					
	Malaise		Esophageal reflux		Skin wound/ulcer					
	Fatigue		Abdominal pain		Skin lesions					
	Anorexia		Abdominal bloating		Mouth sores					
	Unintended weight gain		Abdominal cramps		Redness					
He	ad and Face		Menstrual pain		Swelling					
	Facial Pain		Nausea		Scaling					
	Facial Pressure		Vomiting		Blisters					
Fve	!S		Diarrhea		Breast pain					
_ y 、	Eye pain		Unable to pass flatus		Breast lump					
	Red eyes		Constipation		Nipple discharge					
_	Discharge from eyes		Dark/bloody stools	Ne	urologic					
	Itchy eyes		Rectal bleeding		Frequent headaches					
			Change in color/size of stool		Migraines					
	Blurred vision		Fecal incontinence		Memory loss/confusion					
	Vision changes		nitourinary		Dizziness					
	Corrective lenses		Difficult/painful urination		Burning/prickling sensation					
EN	Г		Loss of urine		Leg numbness					
	Earache				_					
	Loss of hearing		Urinary hesitancy		Leg weakness					
	Ringing ears		Urinary urgency		Tingling					
	Runny nose		Frequent urination		Difficulty walking					
	Nasal congestion		Night time urination		Vertigo					
	Sore throat		Dark urine		Tremors					
	Scratchy throat		Blood in urine	Psy	chiatric					
	Change in voice/hoarseness		Flank pain		Insomnia					
	Dentures		Suprapubic pain		Irritable					
Cai	diovascular		Pelvic pain		Anxiety					
	Chest pain		Foul-smelling vaginal discharge		Depression					
	Racing heart		Heavy menstrual bleeding		Sleep disturbances					
	Leg pain		Painful menstrual cramps		Overwhelming stress					
	Leg swelling		Missed menstrual period		Suicidal ideation					
	Lightheadedness/Fainting		Suspected pregnancy	End	docrine					
	Poor exercise tolerance		Confirmed pregnancy		Hot flashes					
			Difficult/painful intercourse		Night sweats					
	Spiratory		Postmenopausal bleeding		Heat/cold intolerance					
	Shortness of breath	Mu	sculoskeletal		Abnormal thirst					
	Wheezing		Joint pain		Decreased libido					
	Sleeping upright/extra pillow		Joint swelling		Excessive facial/chest/back hair					
	Cough		Joint stiffness		Muscle weakness					
	Dry cough		Muscle pain		Generalized weakness					
	Productive cough		Back pain							
	Clear sputum		Limping		matology/Lymph					
	Colored sputum		Falls		Swollen lymph nodes					
	Vomiting blood		. 4.13		Bleeding gums/Nose bleeds					
	Daytime sleepiness				Easy bleeding					
					Easy bruising					
					Jaundice					