UB|MD OBSTETRICS & GYNECOLOGY

Return Patient Intake Form

Today's Date: _____

Legal Name: _____ Date of Birth: _____

Preferred Name:_____ Preferred Pronouns:_____

Referring Physician: _____ Primary Care Physician: _____

Reason for Today's visit: _____

GYNECOLOGIC HISTORY UPDATE:

Any changes to your gynecologic history since your last visit? ☐ NO ☐ YES

If Yes, explain:_____

First day of last menstrual period:_____

How often are your periods? _____ How many days does your period last? _____

Flow: ☐ Heavy ☐ Average ☐ Light Last Pap smear: _____ ☐ NORMAL ☐ ABNORMAL

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: _____

Last Bone Density: _____ was it abnormal? ☐ NO ☐ YES if yes, explain: _____

SEXUAL HISTORY UPDATE:

Are you sexually active? ☐ NO ☐ YES

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

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

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

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

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

MEDICAL HISTORY UPDATE:

Have there been any changes to your medical history since your last visit? ☐ NO ☐ YES

If Yes, explain: _____

Have you had any surgeries since your last visit? ☐ NO ☐ YES

- If Yes , list procedure, year and hospital

  _____

  _____

FAMILY HISTORY UPDATE:

Have there been any changes to your family medical history since your last visit? ☐ NO ☐ YES

If Yes, explain: _____

(PLEASE TURN OVER AND COMPLETE BACK)

SOCIAL HISTORY UPDATE:

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Engaged ☐ Significant other ☐ Same sex partner

What is your occupation? _____

Do you drink Alcohol? ☐ NO ☐ YES If yes, how much per week? _____

Do you use Recreational Drugs? ☐ NO ☐ YES If yes, specify type, amount and frequency:

_____

Tobacco use: ☐ NEVER ☐ CURRENT (_____# of cigarettes per day) ☐ FORMER (Quit at age _____)

Do you exercise? ☐ NO ☐ YES If yes, specify type and frequency: _____

Allergies (Medication and Environmental): _____

_____

Immunization Update (include all immunization. If actual date is unknown, enter approximate date or year):

Vaccine	Date Received		Vaccine	Date Received
COVID-19			MMR	
Hepatitis A			Meningococcal	
Hepatitis B			Pneumococcal	
HPV			TDAP or TD (circle one)	
Influenza			Varicella	

Medications Update (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	Reason

Pharmacy Name Address Telephone Number

_____

_____ _____

Patient Signature Date

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Review of Systems

Name: _____ Date: _____

Please check all symptoms that you are currently experiencing:

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

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

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