

INITIAL INTAKE FORM

Orange Coast Women's Medical Group, Inc. (949)829-5500

Today's Date: _____

Patient Name: _____ **Birth Date:** _____ **Account #** _____

Important: In order to provide the highest quality of health care possible, it is important that we have the following information. Please answer all of the doctor's questions as accurately as possible. If you do not understand the question please ask for assistance. Thank you.

Please describe the reason(s) for this visit: _____

Drug allergies: _____

List any medications you are taking, including non-prescription drugs, vitamins, and herbals:

Female Genitourinary (Please Complete):

Date of last pap smear? _____	Any problem w/leaking urine? no	yes
Any abnormal pap smears? no	Are you sexually active? no	yes
Date of last mammogram _____	Do you have pain w/intercourse? no	yes
Result of mammogram normal? no	Bleeding between periods? no	yes
Date of last bone density test _____	Vaginal discharge/itching? no	yes
Result on bone density normal? no	Bleeding after intercourse? no	yes

Menstrual History:

Age period began: _____	Average # of days: _____	Do you use hormones? no	yes	
Date of last period: _____	Method of contraception: _____	If so, type: _____		
Frequency of periods _____	Satisfied with this method? no	yes	Any vaginal bleeding? no	yes

Past Medical History:

Have you ever had the following:

Diabetes no	yes	Thyroid dysfunction no	yes	Infertility no	yes
Hypertension no	yes	Major accidents no	yes	Mitral Valve Prolapse no	yes
Heart Dz/High Chol no	yes	Stomach/Intestinal no	yes	Cancer no	yes
Obesity no	yes	Tuberculosis no	yes	Anemia no	yes
Kidney dysfunction no	yes	Asthma no	yes	Glaucoma no	yes
Mental disorder no	yes	Herpes no	yes	AIDS or HIV+ no	yes
Hepatitis/Liver dz no	yes	Anesthetic complication no	yes	Osteopenia/Osteoporosis no	yes

Past Surgical History:

Have you ever had the following:

D & C no	yes	Cryosurgery no	yes		
Hysterectomy no	yes	Breast biopsy no	yes	Colposcopy no	yes
Surgery on tubes/ovaries no	yes	Breast cyst aspiration no	yes	LEEP/Cone biopsy no	yes
Cesarean delivery no	yes	Mastectomy no	yes	Urologic no	yes

Please list any other previous surgeries or any other major illnesses and dates: _____

Obstetrical History (Please Complete):

Year	Wt.	Sex	#wks pregnant	Duration of Labor	C-section?	Complications?
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____

Social History (Please Complete):

Occupation: _____ Marital Status: S M W D

Do you exercise? no yes Have you ever been sexually abused? no yes

Type: _____ Have you ever felt physically or emotionally threatened? no yes

How often? _____ Do you get calcium in your diet? no yes

Smoking (type & amount per day) _____ Supplements: _____

If former smoker, date quit: _____ Alcohol (type and amount per week): _____

Do you use marijuana, cocaine or other drugs? _____

Family Medical History:

Medical Problem	Family Members Affected	Choices: Mother, Father, Sibling, Grandmother, Grandfather
High Cholesterol	<input type="checkbox"/> No <input type="checkbox"/> Yes	Who: _____
Heart Disease	<input type="checkbox"/> No <input type="checkbox"/> Yes	Who: _____
High Blood Pressure	<input type="checkbox"/> No <input type="checkbox"/> Yes	Who: _____
Breast cancer	<input type="checkbox"/> No <input type="checkbox"/> Yes	Who: _____
Melanoma	<input type="checkbox"/> No <input type="checkbox"/> Yes	Who: _____
Diabetes	<input type="checkbox"/> No <input type="checkbox"/> Yes	Who: _____
Ovarian cancer	<input type="checkbox"/> No <input type="checkbox"/> Yes	Who: _____
Stroke	<input type="checkbox"/> No <input type="checkbox"/> Yes	Who: _____
Blood disorder	<input type="checkbox"/> No <input type="checkbox"/> Yes	Who: _____
Depression	<input type="checkbox"/> No <input type="checkbox"/> Yes	Who: _____
Colon cancer	<input type="checkbox"/> No <input type="checkbox"/> Yes	Who: _____
Osteoporosis	<input type="checkbox"/> No <input type="checkbox"/> Yes	Who: _____

Review of Systems (Please Complete):

Do you have now or have you had within the past year:

Const Weight Gain/Loss no yes	CV History of heart attack... no yes	Psych Depression no yes
	History of blood clots	
GI Bloody stools..... no yes	in legs or lungs no yes	Skin Painful breasts no yes
Abdominal pain no yes		Breast lumps..... no yes
Date of last colonoscopy _____	Neuro Seizures no yes	Nipple discharge no yes
	History of stroke no yes	
Endo Night sweats no yes	History of migraines..... no yes	Other _____
Hot flashes..... no ye		_____
	Resp History of asthma no yes	_____
Heme Bruising easily no yes		

I VERIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

X _____
Signature of patient or parent if minor

Date