# Hera Ob/Gyn Medical Group, Inc.

**Date**:_____**Name**:_____**Birthdate**_____

## Patient Intake Form

This form lets us get to know you and know how we can help. Not every question is important to everyone, but the more you can answer, the more we can help. If there is a question that makes you uncomfortable, skip it and discuss it during your visit. Thank you.

### If you need help with this form, please see a front desk staff member.

**Reason for your visit today:** □ Routine Exam □ Pregnancy □ Problem_____

**Primary Care Physician**_____**Pharmacy**_____
**Marital Status**: □ Married □ Single □ Divorced □ Separated □ Widowed
**Occupation**:_____ □ Homemaker □ Unemployed □ Disabled □ Retired

**Are you allergic to any:**

Medications □ Yes □ No If yes, what medication?_____
Latex □ Yes □ No

**What medicines (prescription & over-the-counter), vitamins, supplements do you take regularly?**

| Name | Dosage | How Often? | What is it for? |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**What medical problems do you have or have you had in the past?** □ None

□ Diabetes □ High Blood Pressure
□ Hepatitis □ Kidney Disease
□ Thyroid Disorder □ Migraines
□ Breast Disease □ Blood Clots
□ High Cholesterol □ Depression/Anxiety
□ Cancer _____ (site)
□ Other_____

*Office Use Only*

**What operations have you had in the past?** □ None

□ Hysterectomy (uterus removed) □ Appendix Removed
□ Oophorectomy (ovaries removed) □ Tonsils Removed
□ Tubal Sterilization □ Gallblader Removed
□ Bladder Surgery □ Hernia Repair
□ Breast Implants □ Breast Reduction
□ Breast Biopsy/Lumpectomy □ C-Section(s) How many?___
□ Other_____

*Office Use Only*

**Has anyone in your family had any of the following?** □ None

*Office Use Only*

| | |
|---|---|
| □ Diabetes | □ High Blood Pressure |
| □ High Cholesterol | □ Thyroid Disorder |
| □ Heart Disease | □ Stroke |
| □ Mental Illness | □ Osteoporosis |
| □ Breast Cancer | □ Colon Cancer |
| □ Ovarian Cancer | □ Other_____ |

**Have you ever gotten a period?** □ Yes □ No If no, skip to next section.

How old were you when you got your first period?_____

What was the date that your last normal period began?_____

Please complete the following sentence regarding your periods during the last year:

I get my period every _____ days and it lasts for _____ days. On my heaviest day I use _____ maxi-pads/ tampons. I get cramps with my period. □ Yes □ No If yes, how severe are they on a scale of 1(mild) - 10(severe)? _____

**Have you gone through menopause?** □ Unsure □ Yes □ No If no, skip to next section.

At what age?_____

Have you had any bleeding since then? □ Yes □ No

Have you ever taken hormone replacement? □ Yes □ No

Do you currently take hormone replacement? □ Yes □ No

If yes, what do you take?_____

Are you having any symptoms of menopause? □ Yes □ No

If yes, which ones? □ Hot flashes □ Mood changes □ Vaginal dryness □ Insomnia □ Other_____

**Have you ever been pregnant?** □ Yes □ No

If yes, how many times have you been pregnant?_____

*Office Use Only*

How many living children do you have?_____

How many full term (37+ weeks) live births?_____

How many preterm (less than 37 wks) live births?_____

How many induced abortions?_____

How many spontaneous miscarriages?_____

How many ectopic (tubal) pregnancies?_____

How many stillbirths?_____

Any multiple gestations (twins, triplets, etc)?_____

Are you planning on getting pregnant? □ Yes □ No

If yes, when?_____

Do you or your partner(s) use any kind of birth control? □ Yes □ No □ Not Needed

If yes, what kind?_____

Are you satisfied with this method? □ Yes □ No

Could you be pregnant today? □ Yes □ No

**What sexually transmitted infections have you had in the past?** □ None

| | | |
|---|---|---|
| □ Gonorrhea | □ HIV/AIDS | □ Syphilis |
| □ Chlamydia | □ Genital Herpes | □ Genital Warts/HPV |
| □ PID (Pelvic Inflammatory Disease) | □ Oral Herpes | □ Trichomonas |
| □ Other_____ | Have you had the HPV vaccine? | □ Yes □ No |

**Have you ever had sex?** □ Yes □ No (If no, skip to next section)

Currently your sexual partner(s) are: (check all that apply) □ None

□ Men □ Women □ Transgender FTM □ Transgender MTF

When was the last time you had sex?_____

In the past year how many sexual partner(s) have you had?_____

Currently how many sexual partner(s) do you have?_____

Do you only have sex with each other? □ Yes □ No

Are you practicing "safer sex"? □ Always □ Never □ Sometimes

Do you think you or your partner(s) have a sexually transmitted infection now? □ Yes □ No

Are you having any difficulties with your sex life? □ Yes □ No

| **When was your last?** | | | Date | Results |
|---|---|---|---|---|
| Cervical Pap Smear | □ Unsure | □ Never | | |
| Have you ever had an abnormal pap? | □ Yes | □ No | | |
| Mammogram | □ Unsure | □ Never | | |
| Sexually Transmitted Infection Testing | □ Unsure | □ Never | | |
| HIV testing | □ Unsure | □ Never | | |
| Bone Density Test | □ Unsure | □ Never | | |
| Colorectal Cancer Screening | □ Unsure | □ Never | | |
| Colonoscopy | □ Unsure | □ Never | | |
| Cholesterol/Glucose/Thyroid Labs | □ Unsure | □ Never | | |

**Have you ever used tobacco?** □ Yes □ No If yes, how often?

□ Daily or almost daily □ Less than monthly

□ Weekly □ Quit How long ago?_____

□ Monthly □ Never

**How often in the past year have you had an alcoholic beverage?**

□ Daily or almost daily □ Less than monthly

□ Weekly □ Never

□ Monthly

Have you ever been addicted to alcohol? □ Yes □ No

**How often in the past year have you used marijuana/cannabis, an illegal drug or a prescription drug for non-medical reasons?**

□ Daily or almost daily □ Less than monthly

□ Weekly □ Never

□ Monthly

What substance(s)?_____

Have you ever been addicted? □ Yes □ No

**Patient Signature**_____ **Date Signed**_____