Christy Walker, MD
GYNECOLOGY • COSMETIC SURGERY

PERSONAL INTAKE HISTORY

Patient Name: ______ Birth Date: ______ SSN: ______ Date: ______

Sexual Orientation: ☐ Heterosexual ☐ Homosexual ☐ Bisexual

Martial Status ☐ Married ☐ Single ☐ Widowed ☐ Divorced

Name you would like to use: ______ Employment/Occupation ______

Why have you come to the office today? ______

Is this a new problem? ☐ Yes ☐ No Please explain ______

GYNECOLOGIC HISTORY

PREGNANCY HISTORY

How many pregnancies? ____ Full-term: ____ Pre-term: ____ Still births: ____ Miscarriages: ____ Elective terminations: ____

Date Mo / Yr	# Weeks at delivery	Length of Labor	Birth Weight	Sex M/F	C/S or Vaginal	Anesthesia	Pre-term-Labor	Complication
							☐ Yes ☐ No	
							☐ Yes ☐ No	
							☐ Yes ☐ No	
							☐ Yes ☐ No	

FAMILY HISTORY

Mother: ☐ Living ☐ Deceased Cause: ______ Age: ______

Father: ☐ Living ☐ Deceased Cause: ______ Age: ______

Siblings ☐ Living ☐ Number Deceased Cause(s)/Age(s): ______ Cause(s)/Age(s): ______

Cause(s)/Age(s): ______ Cause(s)/Age(s): ______

Children ☐ Number Living ☐ Number Deceased Cause(s)/Age(s): ______ Cause(s)/Age(s): ______

Illness		Which Relative(s)	Illness		Which Relative(s)
Diabetes	☐	______	Tuberculosis	☐	______
Stroke	☐	______	Birth Defects	☐	______
Heart Disease	☐	______	Drinking or Drug Problems Breast	☐	______
Blood Clots in Lungs or legs	☐	______	Cancer Colon	☐	______
High Blood Pressure	☐	______	Cancer Ovarian	☐	______
High Cholesterol	☐	______	Cancer Uterine	☐	______
Osteoporosis (Weak Bones)	☐	______	Cancer	☐	______
Hepatitis	☐	______	Mental Illness/ Depression	☐	______
HIV/AIDS	☐	______	Alzheimer's Disease	☐	______
			Other	☐	______

SOCIAL HISTORY

	Yes	No
Ever Smoked?	☐	☐
Current Smoker	☐	☐
Alcohol:	☐	☐
	☐	☐

When did you stop smoking? ______

Packs per Day: ______ Years: ______

Drinks Per day: ______ Drinks Per Week: ______

When did you stop drinking? ______

	Yes	No
Are you currently using drugs?	☐	☐
Have you used recreational drugs in the past?	☐	☐
Have you been sexually abused, threatened, or hurt by anyone?	☐	☐
Dairy Product Intake/ Calcium Supplements:	☐	☐

Which drugs? ______

Which products? ______

How many times per week do you exercise? ______

PERSONAL PAST HISTORY OF ILLNESSES

Major Illnesses	Yes	Date	Major Illnesses	Yes	Date	Major Illnesses	Yes	Date
Sexually Transmitted Disease	☐		Chickenpox	☐		Seizures/Convulsions/ Epilepsy	☐	
HIV/ AIDS	☐		Cancer	☐		Bowel problems	☐	
Heart Attack/ Problem	☐		Reflux/ Hiatal hernia/ Ulcers	☐		Glaucoma	☐	
Diabetes	☐		Depression / Anxiety	☐		Cataracts	☐	
High Blood Pressure	☐		Anemia	☐		Arthritis/ Joint Pain/ Back Problems	☐	
Stroke	☐		Blood Transfusion	☐		Broken Bones	☐	
Rheumatic Fever	☐		Thyroid Disease	☐		Hepatitis/Yellow Jaundice/ Liver Disease	☐	
Blood Clots in Lungs or legs	☐		Gallbladder Disease	☐		Other	☐	
Eating Disorder	☐		Headaches	☐		Other	☐	
Collagen Vascular Disease (Lupus)	☐		Fibroids	☐				

OPERATIONS/HOSPITALIZATIONS

Procedure	Date	Reason

CURRENT MEDICATIONS
(Including hormones, vitamins, herbs, nonprescription medications)

Drug Name	Dosage	Frequency of Dosing

Drug Name	Dosage	Frequency of Dosing

Are you allergic to any medication? (Please advise :) ____________

____

REVIEWS OF SYSTEMS

(Please check if any of the following symptoms apply to you now or since adulthood)

	Now	Past
1. Constitutional	☐	☐
Weight Loss	☐	☐
Weight Gain	☐	☐
Fever	☐	☐
Fatigue	☐	☐
Change in Height	☐	☐
Glasses/ Contacts	☐	☐

	Now	Past
2. Eyes	☐	☐
Double Vision	☐	☐
Spots before eyes	☐	☐
Vision Change	☐	☐

3. Ear, Nose, and Throat	Now	Past
Mouth Sores	☐	☐
Dental Problems	☐	☐
Earaches	☐	☐
Ringing in Ears	☐	☐
Hearing problems	☐	☐
Sinus problems	☐	☐
Sore Throat	☐	☐
Chronic Cough	☐	☐

4. Cardiovascular	Now	Past
Painful Breathing	☐	☐
Chest Pain or Pressure	☐	☐
Difficulty Breathing on Exertion	☐	☐
Swelling of Legs	☐	☐
Sore Throat	☐	☐
5. Respiratory	☐	☐
Wheezing	☐	☐
Spitting up Blood	☐	☐
Shortness of Breath	☐	☐
Frequent Diarrhea	☐	☐
Bloody Stool	☐	☐
Nausea/Vomitting/Indigestion	☐	☐
Constipation	☐	☐
Involuntary Loss of gas or Stool	☐	☐

6. Genitourinary	Now	Past
Blood in Urine	☐	☐
Pain with Urination	☐	☐
Strong Urgency to Urinate	☐	☐
Frequent Urination	☐	☐
Incomplete Emptying	☐	☐
Involuntary/ Unintended Urine Loss	☐	☐
Urine Loss when coughing or lifting	☐	☐
Abnormal Bleeding	☐	☐
Painful periods	☐	☐
Premenstrual Syndrome (PMS)	☐	☐
Painful Intercourse	☐	☐
Fibroids	☐	☐
Infertility	☐	☐
DES Exposure	☐	☐
Abnormal Vaginal Discharge	☐	☐

7. Musculoskeletal	Now	Past
Muscle Weakness	☐	☐
Muscle or Joint Pain	☐	☐
8. Skin		
Rash	☐	☐
Sores	☐	☐
Dry Skin	☐	☐
Moles	☐	☐
9. Breast		
Pain in Breast	☐	☐
Nipple Discharge	☐	☐
Lumps	☐	☐
10. Neurologic		
Dizziness	☐	☐
Seizures	☐	☐
Numbness	☐	☐
Trouble Walking	☐	☐
Severe Memory problems	☐	☐
Frequent or Severe Headaches	☐	☐

REVIEW OF SYSTEMS

11. Psychiatrics	Now	Past
Depression or Frequent Crying	☐	☐
Severe Anxiety	☐	☐
12. Endocrine		
Hair Loss	☐	☐
Heat /Cold Intolerance	☐	☐
Abnormal Thirst Hot	☐	☐
Flashes	☐	☐

13. Hematologic Lymphatic		
Frequent Bruises	☐	☐
Cuts Do Not Stop Bleeding	☐	☐
Enlarged Lymph Nodes (Glands)	☐	☐
14. Allergic/Immunologic		
Medication / Allergies	☐	☐
Other Allergies	☐	☐

Form Completed By: ☐ Patient

Name: ______________________________

Date/Time Field [ ]