# MOONTOWER MIDWIFERY & WELLNESS

## NEW GYN PATIENT INTAKE

| | |
|---|---|
| NAME: | DOB: |
| PRIMARY LANGUAGE: | RACE/ETHNICITY: |
| PHONE: | EMAIL: |
| ADDRESS: | |
| PHARMACY: | PHARMACY PHONE: |
| PARTNER NAME: | PARTNER PHONE #: |
| MEDICATIONS: | ALLERGIES: |
| RECENT VACCINES: | |
| PRIMARY CARE PROVIDER: | |
| EMERGENCY CONTACT: | PHONE: |
| MARITAL STATUS: SINGLE MARRIED WIDOWED COMMITTED RELATIONSHIP NON-MONOGAMOUS (CIRCLE ONE) | |

**GYNECOLOGICAL HISOTRY:**

| | | |
|---|---|---|
| 1ST DAY OF YOUR LAST PERIOD: | ARE YOU ON BIRTH CONTROL?<br><br>**YES NO** | WHAT METHOD OF BIRTH CONTROL ARE YOU USING? |
| LAST PAP SMEAR DATE:<br><br>History of ABNORMAL PAP:<br><br>**YES NO**<br><br>**DATE:** | HPV STATUS:<br><br>***NEG POS UNSURE*** | HPV VAX COMPLETE:<br><br>***YES NO UNSURE*** |
| HISTORY OF CERVICAL DYSPLASIA?<br><br>***YES NO*** | HISTORY OF VULVAR DYSPLASIA:<br><br>***YES NO*** | ARE YOU CURRENTLY SEXUALLY ACTIVE?<br><br>***YES NO*** |
| AGE AT 1ST INTERCOURSE: | AGE WHEN YOU STARTED YOUR PERIOD: | DO YOU HAVE SEXUAL TRAUMA: |
| DO YOU HAVE A HISTORY OF THE FOLLOWING: | ❑ ENDOMETRIOSIS<br>❑ FIBROIDS<br>❑ INFERTILITY<br>❑ RECURRENT OVARIAN CYSTS | ❑ PCOS<br>❑ PAINFUL PERIODS<br>❑ OTHER: |

| | |
|---|---|
| HOW LONG ARE YOUR CYCLES (ex 28-30d): | DAYS IRREGULAR: _____ |
| HOW MANY DAYS DO YOU BLEED: | DAYS IRREGULAR: _____ |

**NAME:** **DOB:**

## OBSTETRICAL HISTORY

| | |
|---|---|
| Total # of Pregnancies | |
| Full term: | |
| Premature <37wks: | |
| Abortions induced: | |
| Abortions spontaneous: | |
| Ectopic: | |
| Multiple births: | |
| Living children: | |

**PAST PREGNANCY INFORMATION**

| | | | |
|---|---|---|---|
| **#1 DATE:**_____ | ❑ MALE<br>❑ FEMALE<br>NAME: | **#2 DATE:**_____ | ❑ MALE<br>❑ FEMALE<br>NAME: |
| GESTATIONAL AGE: | WEEKS: _____ DAYS _____ | GESTATIONAL AGE: | WEEKS: _____ DAYS _____ |
| BABY WEIGHT: | LBS_____ OZ _____ | BABY WEIGHT: | LBS_____ OZ _____ |
| MODE OF DELIVERY: | ❑ VAGINAL<br>❑ C/SEC<br>❑ VBAC<br>❑ VAVD | MODE OF DELIVERY: | ❑ VAGINAL<br>❑ C/SEC<br>❑ VBAC<br>❑ VAVD |
| WERE YOU INDUCED: | ❑ NO<br>❑ YES | WERE YOU INDUCED: | ❑ NO<br>❑ YES |
| LENGTH OF LABOR: | | LENGTH OF LABOR: | |
| WAS ANESTHESIA USED: | ❑ NONE<br>❑ EPIDURAL<br>❑ SPINAL<br>❑ GENERAL | WAS ANESTHESIA USED: | ❑ NONE<br>❑ EPIDURAL<br>❑ SPINAL<br>❑ GENERAL |
| PRE-TERM LABOR? | ❑ NO<br>❑ YES | PRE-TERM LABOR? | ❑ NO<br>❑ YES |
| WHERE DID YOU DELIVER? | ❑ HOME<br>❑ BIRTHING CENTER<br>❑ HOSPITAL | WHERE DID YOU DELIVER? | ❑ HOME<br>❑ BIRTHING CENTER<br>❑ HOSPITAL |
| **#3 DATE:**_____ | ❑ MALE<br>❑ FEMALE<br>NAME: | **#4 DATE:**_____ | ❑ MALE<br>❑ FEMALE<br>NAME: |
| GESTATIONAL AGE: | WEEKS: _____ DAYS _____ | GESTATIONAL AGE: | WEEKS: _____ DAYS _____ |
| BABY WEIGHT: | LBS_____ OZ _____ | BABY WEIGHT: | LBS_____ OZ _____ |
| MODE OF DELIVERY: | ❑ VAGINAL<br>❑ C/SEC<br>❑ VBAC<br>❑ VAVD | MODE OF DELIVERY: | ❑ VAGINAL<br>❑ C/SEC<br>❑ VBAC<br>❑ VAVD |
| WERE YOU INDUCED: | ❑ NO<br>❑ YES | WERE YOU INDUCED: | ❑ NO<br>❑ YES |
| LENGTH OF LABOR: | | LENGTH OF LABOR: | |
| WAS ANESTHESIA USED: | ❑ NONE<br>❑ EPIDURAL<br>❑ SPINAL<br>❑ GENERAL | WAS ANESTHESIA USED: | ❑ NONE<br>❑ EPIDURAL<br>❑ SPINAL<br>❑ GENERAL |
| PRE-TERM LABOR? | ❑ NO<br>❑ YES | PRE-TERM LABOR? | ❑ NO<br>❑ YES |
| WHERE DID YOU DELIVER? | ❑ HOME<br>❑ BIRTHING CENTER<br>❑ HOSPITAL | WHERE DID YOU DELIVER? | ❑ HOME<br>❑ BIRTHING CENTER<br>❑ HOSPITAL |

**NAME:** **DOB:**

## SOCIAL HISTORY

| | |
|---|---|
| HISOTRY OF DOMESTIC VIOLENCE? | ❑ YES<br>❑ NO<br>COMMENTS: |
| ARE YOU CURRENTLY IN SCHOOL? | ❑ YES FOR:_____<br>❑ NO |
| ARE YOU CURRENTLY EMPLOYED? | ❑ YES<br>❑ NO<br>OCCUPATION:_____ |
| DO YOU HAVE AN ADVANCE DIRECTIVE? | ❑ YES<br>❑ NO |
| IS BLOOD TRANSFUSION ACCEPTABLE? | ❑ YES<br>❑ NO |
| WHAT TYPE OF DIET ARE YOU FOLLOWING? | ❑ REGULAR<br>❑ VEGETARIAN<br>❑ VEGAN<br>❑ DIABETIC<br>❑ SPECIFIC:_____ |
| WHAT IS YOUR EXERCISE LEVEL? | ❑ NONE<br>❑ OCCASIONAL<br>❑ MODERATE<br>❑ HEAVY |
| HOW MANY DAYS A WEEK DO YOU EXERCISE? | ❑ LESS THAN 1 TIME PER WEEK<br>❑ 1-2 TIMES A WEEK<br>❑ 3-4 TIMES A WEEK<br>❑ 5-7 TIMES A WEEK |
| DO YOU SMOKE TOBACCO? | ❑ NEVER SMOKER<br>❑ FORMER SMOKER<br>❑ OCCASIONAL SMOKER<br>❑ CURRENT EVERYDAY SMOKER<br>❑ CURRENT SOME DAY SMOKER |
| DO YOU DRINK ALCOHOL? | ❑ NONE<br>❑ OCCASIONAL<br>❑ MODERATE<br>❑ HEAVY |
| DO YOU DO ANY ILLICIT OR RECREATIONAL DRUGS? | ❑ YES<br>❑ NO |
| WHAT IS YOUR LEVEL OF CAFFEINE CONSUMPTION? | ❑ NONE<br>❑ OCCASIONAL<br>❑ MODERATE<br>❑ HEAVY |
| SEXUAL ORIENTATION? | |
| ARE YOU INTERESTED IN STD TESTING? | ❑ YES<br>❑ NO |
| HAVE YOU EVER HAD A SEXUALLY TRANSMITTED DISEASE (STD)? IF SO, WRITE DATE AND IF TREATED | ❑ NONE<br>❑ HERPES<br>❑ HPV<br>❑ GENITAL WARTS<br>❑ HEPATITIS<br>❑ SYPHILLIS (WHEN?)<br>❑ CHLAMYDIA<br>❑ GONORRHEA<br>❑ HIV<br>❑ MRSA |

## SURGICAL HISTORY

PLEASE LIST ANY SURGERIESE OR HOSPITALIZATION YOU HAVE UNDERGONE (D&C, HYSTERECTOMY, C/SECTION, AUGMENTATIONS)

| YEAR OF SURGERY | TYPE/REASON | MD | HOSPITAL |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**Name:** **DOB:**

# PATIENT PERSONAL AND FAMILY HISTORY

PLACE AN "X" IN THE WHITE BOXES THAT APPLY

| | YOU | MOTHER | FATHER | MATERNAL GRANDMA | MATERNAL GRANDPA | PATERNAL GRANDMA | PATERNAL GRANDPA | SIBLINGS | CHILDREN |
|---|---|---|---|---|---|---|---|---|---|
| ANEMIA | | | | | | | | | |
| ASHKENAZI JEWISH | | | | | | | | | |
| ARTHRITIS | | | | | | | | | |
| ASTHMA | | | | | | | | | |
| BIRTH DEFECT (CLEFT PALATE, SPINA BIFIDA) | | | | | | | | | |
| BLOOD DISORDER | | | | | | | | | |
| BREAST DISORDER | | | | | | | | | |
| CANCER, BREAST | | | | | | | | | |
| CANCER, COLON | | | | | | | | | |
| CANCER, OVARIAN | | | | | | | | | |
| CANCER, UTERINE/ENDOMETRIAL | | | | | | | | | |
| COLON POLYPS | | | | | | | | | |
| DIABETES | | | | | | | | | |
| ENDOMETRIOSIS | | | | | | | | | |
| EPILEPSY | | | | | | | | | |
| GALLBLADDER DISEASE | | | | | | | | | |
| GENETIC DISORDER (MENTAL RETARDATION, CYSTIC FIBROSIS) | | | | | | | | | |
| GLAUCOMA | | | | | | | | | |
| HEART DISEASE OR MITAL VALVE PROLAPS | | | | | | | | | |
| HIGH BLOOD PRESSURE | | | | | | | | | |
| HIGH CHOLESTEROL | | | | | | | | | |
| KIDNEY DISORDER/ DISEASE | | | | | | | | | |
| MENTALL ILLNESS TYPE? | | | | | | | | | |
| MENSTRUAL IRREGULARITIES | | | | | | | | | |
| OSTEOPOROSIS | | | | | | | | | |
| PELVIC INFLAMMATORY DISEASE | | | | | | | | | |
| STROKE | | | | | | | | | |
| THYROID DISORDER | | | | | | | | | |
| UTERINE ANOMALIES | | | | | | | | | |
| STILL LIVING? | X | | | | | | | | |
| DECEASED AT AGE? | - | | | | | | | | |
| OTHER | | | | | | | | | |