The Cobb Group's Obstetric and Gynecologic Intake History

NAME:_____ BIRTH DATE:____/____/_____ DATE:____/____/____

ADDRESS:_____

CITY_____ STATE/ZIP:_____

HOME TEL:( )_____ WORK TEL:( )_____

EMPLOYER:_____ INSURANCE:_____

NAME OF SPOUSE/PARTNER:_____ REFERRED BY:_____

DID YOUR DOCTOR SEND YOU TO US? O YES O NO

WHAT BRINGS YOU TO OUR OFFICE? O I AM PREGNANT O I WANT TO BE PREGNANT
O ANNUAL EXAM/YEARLY O BIRTH CONTROL/TUBAL O PELVIC PAIN O BLEEDING PROBLEMS
O LOOSING URINE/TROUBLE WITH URINATION O MENOPAUSE
O OTHER _____

REVIEW OF SYSTEMS:
DO YOU EVER LEAK URINE OR HAVE TO WEAR A LINER/PAD BECAUSE OF URINE? O YES O NO
DO YOU HAVE HOT FLASHES/NIGHT SWEATS? O YES O NO

PERSONAL PAST HISTORY

DO YOU OR HAVE YOU HAD ANY OF THESE MAJOR ILLNESSES	YES	NO	DO YOU OR HAVE YOU HAD ANY OF THESE MAJOR ILLNESSES	YES	NO
Asthma			Cancer		
Pneumonia			Ulcers		
Chronic Lung Disease			Depression/anxiety		
Kidney 0 Infections 0 stones			Anemia		
Seizures/convulsions/epilepsy			Blood transfusions		
Blood Clots in leg or lung (DVT/PE)			Bowel trouble		
Heart Trouble/murmur			Glaucoma		
Diabetes			Arthritis/joint pain		
High Blood Pressure			Fracture		
Stroke			Hepatitis/Yellow jaundice		
Rheumatic Fever			Thyroid Disease (0 Hypothyroid 0 Hyperthyroid)		
Other? Please list:					

OPERATIONS/SURGERIES

Type of Surgery Reason	Date	Other types of Surgery Reason	Date
Hysterectomy? O Yes O No			
Tubal? O Yes O No			
C-Section? O Yes O No			

HOSPITALIZATIONS/INJURIES/ILLNESSES

Type/Reason	Date	Type/Reason	Date

OB/GYN HISTORY

Number of: Vaginal Births ( ) C-Sections ( )		Number of: Term Births ( )	
Miscarriages ( ) Tubal Pregnancies ( ) Abortions ( ) Have you had an abnormal Pap Smear? O Yes O No O LEEP (year) O Cold Knife Cone (year) O Cryo or freezing of cervix (year)		Preterm Births ( ) Multiples [twins, triplets] ( ) Living Children ( ) Have you ever had: O none of these O Gonorrhea O Chlamydia O Syphilis O Herpes O Trichamonas O HIV O PID/Pelvic Inflammatory Disease O HPV O Genital Warts	

CURRENT MEDICATIONS

Drug Name/Dose/Times a day (if more than 4, please attach list and mark here 0 Med list attached)

DO YOU TAKE VITAMINS OR SUPPLEMENTS? O YES O NO IF YES, WHICH TYPE?_____

_____

FAMILY HISTORY

Illness	Y/N	Relative	Illness	Y/N	Relative
Diabetes			Uterine Cancer		
Stroke			Breast Cancer		
Heart Disease			Colon Cancer		
High Blood Pressure			Ovarian Cancer		
Problems with Anesthesia					

OTHER FAMILY HISTORY?

SOCIAL HISTORY

Have you or do you Smoke?	Yes	☐	No	☐	Packs per day_____	For _____ years	
Have you quit smoking	Yes	[ ]	No	[ ]	When did you last smoke?	(month/year) _____	
Do you drink Alcohol	Yes	☐	No	☐	Drinks per day_____	Per week___ Per Month ___	
Are you an Alcoholic	Yes	[ ]	No	[ ]	If yes, date of your last drink?	(month/year) _____	
Drug Use	Yes	☐	No	☐	Type(s) _____	_____	
Are you in recovery	Yes	[ ]	No	[ ]	If yes, since when?	(month/year) _____	

Personal Profile

Marital Status	Married	☐	Single	☐	Widowed ☐	Divorced	☐
Number of Living Children_____							
Number of people in household_____							
School Completed	High School	☐	College	☐	Graduate Degree ☐	Other	☐
Current or most recent job_____							

Do you ever feel like you are in danger in your home? O Yes O No

Completed by: [] Patient [] Office Nurse [] Parent [] Physician ☐Other _____

Printed name of patient:_____

Signature of patient:_____Date_____

Physician Signature:_____Date_____

Annual Review of History

Date reviewed:_____ Patient Initials _____ Physician Signature:_____

Date reviewed:_____ Patient Initials _____ Physician Signature:_____

Date reviewed:_____ Patient Initials _____ Physician Signature:_____

Date reviewed:_____ Patient Initials _____ Physician Signature:_____