MISSOULA WOMEN'S HEALTHCARE NEW PATIENT INTAKE FORM

Temp:	**Weight:**
Pulse:	**Height:**
O2:	**BP:**

Full Name:

DOB: *Age:*

Preferred Name: *Preferred Pronouns:*

Best phone number:

Okay to leave medical messages on your voicemail? □ *Yes* □ *No*

What health questions or concerns would you like to address today?

GYNECOLOGIC HISTORY:

1. Are you postmenopausal? □ Yes □ No (If yes, please skip to question #7)
2. First day of your last menstrual period (LMP)? _____
3. Concerns about your menstrual cycle? □ Yes □ No
4. If so, which of the following concerns would you like to discuss today?
   □ Irregular or missed periods □ Painful periods □ Heavy period flow □ Other: _____
5. Current method of birth control/contraception? _____
6. Satisfied with your current contraceptive method? □ Yes □ No
7. When was your last Pap smear (month/year), and what was the result? _____
8. History of abnormal Pap smear and/or positive HPV result? □ Yes (treatment/date: _____) □ No
9. Have you received the human papilloma virus (HPV) vaccine? □ No □ Yes – once □ Yes – 2 □ Yes – 3
10. If ≥ 40, when was your last screening mammogram and what was the result? _____
11. History of breast concerns or surgeries? □ Yes □ No Details: _____
12. History of recurrent yeast infections or bacterial vaginosis (BV)? □ No □ Yes – yeast □ Yes – BV □ Yes - both
13. History of recurrent urinary tract infections? □ Yes □ No Details: _____
14. Are you experiencing pelvic floor problems (prolapse, leaking of urine, pelvic pain/pressure, exercise limitations)?
Details: _____
15. Do you have a history of oral or genital herpes (HSV)? □ Yes □ No
16. If you are sexually active, please mark if any of the following pertain to you:
□ Pain with sex □ Decreased sex drive □ Vaginal dryness □ New partner(s), I would like infection screening □ Other:_____
17. Please mark if you have a history of any of the following gynecologic conditions:
□ Fibroids □ Endometriosis □ PCOS □ Other:_____

PREGNANCY HISTORY

Total # of ALL pregnancies	Total # of births after 37 weeks	Total # of births between 20 – 37 weeks	Total # of miscarriages, terminations & ectopics before 20 weeks	Total # of living children

Specific pregnancy, birth or postpartum complications:

SURGICAL HISTORY

◦ Have you ever had surgery or been hospitalized? □ Yes □ No
◦ If yes, please provide details: _____

ALLERGIES

◦ Do you have any medication allergies? □ Yes □ No
◦ If yes, please provide details: _____

PERSONAL & FAMILY HEALTH HISTORY

Please check the box if you or a close relative has experienced any of the following conditions:

Self	Family		
☐	☐	1.)	Diabetes or gestational diabetes
☐	☐	2.)	High blood pressure
☐	☐	3.)	Heart disease (heart attack, high cholesterol, heart failure)
☐	☐	4.)	Autoimmune disorder (ie. MS, lupus, rheumatoid arthritis)
☐	☐	5.)	Kidney or liver problems
☐	☐	6.)	Seizures
☐	☐	7.)	Mood disorders (depression, anxiety, bipolar disorder, OCD, PTSD etc)
☐	☐	8.)	Substance abuse, trauma, or violence
☐	☐	9.)	Thyroid problems: _____
☐	☐	10.)	Blood clots, pulmonary embolus, or stroke
☐	☐	11.)	Migraines (with aura? ☐ Yes ☐ No)
☐	☐	12.)	Lung problems (ie. asthma)
☐	☐	13.)	Breast, ovarian, endometrial or colon cancer < age 50: _____
☐	☐	14.)	Known genetic mutations (ie. BRCA 1 or 2) or high-risk heritage (ie. Ashkenazi Jewish)
☐	☐	15.)	Other cancers: _____

Please describe any other significant personal or family health history:

MEDICATIONS (please include all prescription medications as well as vitamins/supplements that you take) ☐ No medications

Medication Name	Amount	Frequency	Prescribing Provider (if applicable)

PREFERRED PHARMACY: _____

HEALTH SCREENING

◦ Date of last wellness labs, and any abnormal results: _____
◦ Do you use tobacco or vape ? ☐ No ☐ Yes (if so, how much per day?) _____
◦ Do you drink alcohol ? ☐ No ☐ Yes (if so, how much per week?) _____
◦ Do you exercise? ☐ No ☐ Yes (if so, what type & how much per week?) _____

DEPRESSION SCREENING

◦ In the past 2 weeks, have you experienced little interest or pleasure in doing things?
☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day
◦ In the past 2 weeks, have you felt down, depressed or hopeless?
☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day
◦ In the past few weeks, have you wished you were dead? ☐ No ☐ Yes

ANXIETY SCREENING

◦ In the past 2 weeks, have you been feeling nervous, anxious or on edge?
☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day
◦ In the past 2 weeks, have you not been able to stop or control worrying?
☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day