SOVEREIGN WOMEN'S HEALTHCARE
1875 OLD ALABAMA RD.
Suite 210
ROSWELL, GA 30076

FOR OFFICE USE ONLY
☐ NEW PATIENT
☐ ESTABLISHED PATIENT
☐ CONSULTATION
☐ ANNUAL EXAM

PATIENT INTAKE HISTORY

ID NO: _________________________ DATE: ________________________________

PATIENT NAME: ____ BIRTHDATE: ___________________________

WHY HAVE YOU COME TO THE OFFICE TODAY? ____

____

WHAT IS THE NAME OF YOUR PRIMARY CARE PHYSICIAN?

IS THIS A NEW PROBLEM? ____

PLEASE DESCRIBE YOUR PROBLEM: *(INCLUDING WHERE IT IS, HOW SEVERE IT IS, AND HOW LONG IT HAS LASTED)*

____

____

____

PERSONAL PAST HISTORY OF ILLNESSES

MAJOR ILLNESSES	YES (DATE)	NO	NOT SURE	MAJOR ILLNESSES	YES (DATE)	NO	NOT SURE
ABNORMAL PAP				GLAUCOMA			
ANEMIA				HEADACHES			
ANXIETY				HEART ATTACK			
ARTHRITIS				HEART DISEASE			
ASTHMA				HEPATITIS			
BLEEDING DISORDERS:__________________				HIATAL HERNIA			
BLOOD CLOTS IN LUNGS (PE)				HIGH BLOOD PRESSURE / HYPERTENSION			
BLOD CLOTS IN LEGS (DVT)				INFERTILITY			
BLOOD TRANSFUSIONS				JOINT PAIN			
BOWEL PROBLEMS				KIDNEY INFECTION			
BROKEN BONES:______________________				KIDNEY STONES			
CANCER:				LUPUS (SLE)			
BREAST				MITRAL VALVE PROLAPSE (MVP)			
CERVIX				PNEUMONIA			
COLON				REFLUX			
OVARY				SARCOIDOSIS			
THYROID				SEXUALLY TRANSMITTED DISEASE-			
UTERINE				TRICHOMONAS			
OTHER:___________________________				CHLAMYDIA			
CATARACTS				HPV			
CHICKEN POX				HERPES, GENITALIS			
COLONIC POLYPS				GONORRHEA			
DEPRESSION				GENITAL WARTS			
DIABETES,TYPE II (Adult Onset)				HIV/AIDS			
DIABETES,TYPE I (Juvenile Onset)				STROKE (CVA)			
EATING DISORDERS:___________________				THYROID DISEASE			
ENDOMETRIOSIS				TUBERCULOSIS			
FIBROIDS				ULCERS			
GALLBLADDER DISEASE				URINARY TRACT INFECTION (UTI)			
OTHER: ______________________________				OTHER:_____________________________			

PATIENT INTAKE HISTORY

PATIENT NAME	BIRTH DATE: / /	ID NO:	DATE: / /

PREVENTATIVE HEALTH MAINTENANCE

TEST	DATE	WAS IT NORMAL? IF NO, PLEASE EXPLAIN
LAST PAP SMEAR		
LAST MAMMOGRAM		
HAVE YOU EVER HAD A BREAST BIOPSY		
LAST PELVIC ULTRASOUND		
LAST COLONOSCOPY		
LAST BONE DENSITY SCAN		
DO YOU TAKE A CALCIUM SUPPLEMENT		

CURRENT MEDICATIONS

(Including hormones, vitamins, herbs, nonprescription medications)

DRUG NAME	DOSAGE	WHO PRESCRIBED	DRUG NAME	DOSAGE	WHO PRESCRIBED

SURGERIES/HOSPITALIZATIONS

REASON	DATE	HOSPITAL

ALLERGIC/IMMUNOLOGIC

ALLERGIC/IMMUNOLOGIC	NOW	PAST	NOT SURE	
MEDICATION ALLERGIES	☐	☐	☐	
IF ANY, PLEASE LIST ALLERGY AND TYPE OF REACTION:				
LATEX ALLERGY	☐	☐	☐	
OTHER ALLERGIES	☐	☐	☐	
PLEASE LIST ALLERGY AND TYPE OF REACTION:				

FAMILY HISTORY

MOTHER- ☐ LIVING ☐ DECEASED-CAUSE:		AGE:
FATHER- ☐ LIVING ☐ DECEASED-CAUSE:		AGE:
SIBLINGS- NUMBER LIVING:	NUMBER DECEASED	CAUSE(S)/AGE(S)
CHILDREN- NUMBER LIVING	NUMBER DEEASED	CAUSE(S)/AGE(S)

ILLNESS	YES	WHICH RELATIVE(S) AND AGE OF ONSET
DIABETES	☐	
STROKE	☐	
HEART DISEASE	☐	
BLOOD CLOTS IN LUNGS OR LEGS	☐	
HIGH BLOOD PRESSURE	☐	
HIGH CHOLESTEROL	☐	
OSTEOPOROSIS (WEAK BONES)	☐	
BIRTH DEFECTS	☐	
ALCOHOL OR DRUG PROBLEMS	☐	
BREAST CANCER	☐	
COLON CANCER	☐	
OVARIAN CANCER	☐	
UTERINE/CERVICAL CANCER	☐	
ALZHEIMER'S DISEASE	☐	
OTHER (*Explain*)	☐	

PATIENT INTAKE HISTORY *(CONTINUED)*

PATIENT NAME	BIRTH DATE / /	ID NO:	DATE: / /

GYNECOLOGIC HISTORY

MENOPAUSE STATUS (PRE/PERI/POST)?	IF MENOPAUSAL, AT WHAT AGE?
LAST NORMAL MENSTRUAL PERIOD (FIRST DAY): / /	
AGE PERIODS BEGAN:	
ARE YOUR CYCLES REGULAR?	
LENGTH OF PERIODS (NUMBER OF DAYS OF BLEEDING):	
NUMBER OF DAYS BETWEEN PERIODS:	
ANY BLOODCLOTS?	
ANY BREAKTHROUGH BLEEDING?	
HOW MANY PADS OR TAMPONS DO YOU USE PER DAY?	
ARE YOU CURRENTLY SEXUALLY ACTIVE?	
HAVE YOU EVER HAD SEX?	
NUMBER OF SEXUAL PARTNERS (LIFETIME):	
PRESENT METHOD OF BIRTH CONTROL:	
HAVE YOU EVER USED AN INTRAUTERINE DEVICE (IUD)?	IF YES, FOR HOW LONG?
DO YOU DO BREAST SELF EXAMINATIONS?	

OBSTETRIC HISTORY

	NUMBER		NUMBER		NUMBER
PREGNANCIES		ABORTIONS		MISCARRIAGES	
PREMATURE BIRTHS (<37 WEEKS)		LIVE BIRTHS		LIVING CHILDREN	
ECTOPICS					

NO.	BIRTH DATE	WEIGHT AT BIRTH	BABY'S SEX	WEEKS PREGNANT	TYPE OF DELIVERY (VAGINAL, CESAREAN, ETC.)
1.					
2.					
3.					
4.					

ANY PREGNANCY COMPLICATIONS?

☐ DIABETES ☐ HYPERTENSION/HIGH BLOOD PRESSURE ☐ PREECLAMPSIA/TOXEMIA ☐ OTHER

ANY HISTORY OF DEPRESSION BEFORE OR AFTER PREGNANCY? ☐ NO ☐ YES, HOW TREATED

SOCIAL HISTORY

	YES	NO	
EVER SMOKED? CURRENT SMOKING PACKS PER DAY: YEARS:	☐	☐	
ALCOHOL DRINKS PER DAY: DRINKS PER WEEK: TYPE OF DRINK:	☐	☐	
DRUG USE	☐	☐	
SEAT BELT USE	☐	☐	
REGULAR EXERCISE HOW LONG AND HOW OFTEN?	☐	☐	
DAIRY PRODUCT INTAKE AND/OR CALCIUM SUPPLEMENTS DAILY INTAKE:	☐	☐	
HEALTH HAZARDS AT HOME OR WORK?	☐	☐	
HAVE YOU BEEN SEXUALLY ABUSED, THREATENED, OR HURT BY ANYONE?	☐	☐	
DO YOU HAVE AN ADVANCE DIRECTIVE (LIVING WILL)?	☐	☐	
ARE YOU AN ORGAN DONOR?	☐	☐	

PERSONAL PROFILE

SEXUAL ORIENTATION:	☐ HETEROSEXUAL ☐ HOMOSEXUAL ☐ BISEXUAL
MARITAL STATUS:	☐ MARRIED ☐ LIVING WITH PARTNER ☐ SINGLE ☐ WIDOWED ☐ DIVORCED
NUMBER OF LIVING CHILDREN:	
NUMBER OF PEOPLE IN HOUSEHOLD:	
SCHOOL COMPLETED:	☐ HIGH SCHOOL ☐ SOME COLLEGE/AA DEGREE ☐ COLLEGE ☐ GRADUATE ☐ OTHER
CURRENT OR MOST RECENT JOB:	
TRAVEL OUTSIDE THE UNITED STATES?	LOCATION(S):

PATIENT INTAKE HISTORY *(CONTINUED)*

PATIENT NAME	D.O.B. / /	ID NO:	DATE

REVIEW OF SYSTEMS

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

		NOW	NOT SURE			NOW	NOT SURE
1.	**CONSTITUTIONAL**				**GENITOURINARY (CONT'D)**		
	WEIGHT LOSS	☐	☐		INCOMPLETE EMPTYING	☐	☐
	WEIGHT GAIN	☐	☐		INVOLUNTARY/UNINTENDED URINE LOSS	☐	☐
	FEVER	☐	☐		URINE LOSS WHEN COUGHING OR LIFTING	☐	☐
	FATIGUE	☐	☐		ABNORMAL BLEEDING	☐	☐
	CHANGE IN HEIGHT	☐	☐		PAINFUL PERIODS	☐	☐
2.	**EYES**				PREMENSTRUAL SYNDROME (PMS)	☐	☐
	DOUBLE VISION	☐	☐		PAINFUL INTERCOURSE	☐	☐
	SPOTS BEFORE EYES	☐	☐		ABNORMAL VAGINAL DISCHARGE	☐	☐
	VISION CHANGES	☐	☐	8.	**MUSCULOSKELETAL**		
	GLASSES/CONTACTS	☐	☐		MUSCLE WEAKNESS	☐	☐
3.	**EAR. NOSE, AND THROAT**				MUSCLE OR JOINT PAIN	☐	☐
	EARACHES	☐	☐	9a.	**SKIN**		
	RINGING IN EARS	☐	☐		RASH	☐	☐
	HEARING PROBLEMS	☐	☐		SORES	☐	☐
	SINUS PROBLEMS	☐	☐		DRY SKIN	☐	☐
	SORE THROAT	☐	☐		MOLES (GROWTH OR CHANGE(S)	☐	☐
	MOUTH SORES	☐	☐	9b.	**BREASTS**		
	DENTAL PROBLEMS	☐	☐		PAIN IN BREAST	☐	☐
4.	**CARDIOVASCULAR**				NIPPLE DISCHARGE	☐	☐
	CHEST PAIN OR PRESSURE	☐	☐		LUMPS	☐	☐
	DIFFICULTY BREATHING ON EXERTION	☐	☐	10.	**NEUROLOGIC**		
	SWELLING OF LEGS	☐	☐		DIZZINESS	☐	☐
	RAPID OR IRREGULAR HEARTBEAT	☐	☐		SEIZURES	☐	☐
5.	**RESPIRATORY**				NUMBNESS	☐	☐
	PAINFUL BREATHING	☐	☐		TROUBLE WALKING	☐	☐
	WHEEZING	☐	☐		MEMORY PROBLEMS	☐	☐
	SPITTING UP BLOOD	☐	☐		FREQUENT HEADACHES	☐	☐
	SHORTNESS OF BREATH	☐	☐	11.	**PSYCHIATRIC**		
	CHRONIC COUGH	☐	☐		DEPRESSION OR FREQUENT CRYING	☐	☐
6	**GASTROINTESTINAL**				ANXIETY	☐	☐
	FREQUENT DIARRHEA	☐	☐	12.	**ENDOCRINE**		
	BLOODY STOOL	☐	☐		HAIR LOSS	☐	☐
	NAUSEA/VOMITING/INDIGESTION	☐	☐		HEAT/COLD INTOLERANCE	☐	☐
	CONSTIPATION	☐	☐		ABNORMAL THIRST	☐	☐
	INVOLUNTARY LOSS OF GAS OR STOOL	☐	☐		HOT FLASHES	☐	☐
7.	**GENITOURINARY**			13.	**HEMATOLOGIC/LYMPHATIC**		
	BLOOD IN URINE	☐	☐		FREQUENT BRUISES	☐	☐
	PAIN WITH URINATION	☐	☐		CUTS DO NOT STOP BLEEDING	☐	☐
	STRONG URGENCY TO URINATE	☐	☐		ENLARGED LYMPH NODES (GLANDS)	☐	☐
	FREQUENT URINATION	☐	☐				

IMMUNIZATIONS/TEST

	DATE		DATE
TETANUS-DIPHTHERIA BOOSTER		INFLUENZA VACCINE 9FLU SHOT)	
HEPATITIS A VACCINE		HEPATITIS B VACCINE	
VARICELLA (CHICKENPOX) VACCINE		PNEUMOCOCCAL (PNEUMONIA) VACCINE	
MEASLES-MUMPS-RUBELLA (MMR) VACCINE		TUBERCULOSIS (TB) SKIN TEST RESULT	
HPV VACCINE (GARDASIL)			

I have answered the questions on this form accurately and to the best of my knowledge:

Patient Signature: ______________________________ *Date:* ____________________