Women's Care Consultants
Washington University Clinical Associates

Please circle the provider you are seeing today:

Sarah Cusworth, MD
Jennifer Meyer, MD
Timothy Philpott, MD
Angela Reining, MD
Terri Sippel, WHNP-BC
Layna Schultz, WHNP-BC

OBSTETRICS AND GYNECOLOGY INTAKE FORM

(Please Fill Out Completely)

Today's Date:____________________________ **Referred by**:____________________________

Patient Information

Name (First/Last):

Preferred Name:

Sex Assigned at Birth: __ Female __ Male

Gender identity: __ Female __ Male __Other:

Date of Birth:

Occupation/employer:

Pronouns:
__ She/Her __He/Him
__They/Them Other:_______

Reason for Visit:

Allergies

__ I have no medication allergies

Latex allergy? __ Yes __ No

Medication allergies and reactions:

Medications (Please check here if no medications are currently taken: ____)

Name of Medication	Strength / Dose	Frequency Taken	Reason for Taking	Provider Clarification (Office Use Only)

Gynecologic Surgeries

Have you had any of the following removed (check all that apply)?

__ Uterus
__ Cervix
__ Left ovary
__ Right ovary
__ Left tube
__ Right tube
__ Fibroid(s)
__ Uterine polyps
__ LEEP

Your gynecologic surgery was done:
___ Laparoscopically (year______)
___ Robotically (year______)
___ Open / laparotomy (year______)
___ Hysteroscopically (year______)

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General Surgery History (Please use the back of the page if needed.)

Year	Type of Surgery	Year	Type of Surgery	Year	Type of Surgery

Gynecologic History (may skip questions that do not apply)

Age of first period:	Menstrual periods: __ Regular __ Irregular	First day of last period: ___/___/______	Flow (check one): __ Light __ Moderate __ Heavy	Days between cycles: _________ Days of bleeding: __________
Do you have pain with periods? __ Yes __ No	Date of last pap smear: ___/___/______	Last pap smear: __ Normal __ Abnormal	If last pap smear was abnormal: __ Colposcopy (year:________) __ LEEP/Conization (year:________) __ Cryosurgery (year:________)	
Are you sexually active? __ Yes __ No	Current partner(s): __ Male __ Female __ Both __ Other __ N/A		Have you had a new partner within the last six months? __ Yes __ No	
Current method of preventing pregnancy:______________________ If IUD, list the name/insertion date:___________________________			Are you interested in getting pregnant within the next year? __ Yes __ No	

Infection history (check all that apply):

__ None	__ Chlamydia	__ HPV	__ Trichomoniasis
__ Genital Herpes	__ Pelvic inflammatory disease	__ HIV/AIDS	__ Other:
__ Gonorrhea	__ Genital warts	__ Syphilis	

Have you ever had a mammogram? __ Yes __ No Date:___/___/______ __ Normal __ Abnormal
Have you ever had a bone density scan? __ Yes __ No Date:___/___/______ __ Normal __ Abnormal
Have you ever had a colonoscopy/Cologuard? __ Yes __ No Date:___/___/______ __ Normal __ Abnormal
Have you ever received the HPV vaccine? __ Yes __ No*
*If not, are you interested in discussing the HPV vaccine? __ Yes __ No

Obstetric History (Please use the back of the page if needed.)

Year	Pregnancy Outcome (vaginal birth, c-section, miscarriage, abortion)	Length of Pregnancy (months & weeks)	Child's Name	Sex of Child	Child's Birth Weight	Living?	Delivery Facility	Complications (preterm labor, high blood pressure, diabetes, etc.)

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Please list names of any adopted children:

Medical Problems

Have you had any of the following (check all that apply)?

__ High blood pressure
__ Stroke
__ Cancer (type:________)
__ Heart disease
__ Migraine (aura: Y/N)
__ Seizures
__ Blood clots (legs or lungs)
__ High cholesterol
__ Ulcers
__ Asthma
__ Diabetes
__ Other:______________

Family History

Condition	Relationship to You	Age at Diagnosis	Condition	Relationship to You	Age at Diagnosis
Breast Cancer			Clotting Problems		
Ovarian Cancer			Osteoporosis		
Uterine Cancer			Other:		
Colon Cancer			Other:		

Social History

Partner's name:________________________________ Partner's occupation:________________________________

Do you smoke cigarettes or vape?
__ No
__ Yes, number per day:__
Years smoked:___Year quit:___

Do you drink alcohol?
__ No
__ Yes, number per day:__
Number per week:___

Do you use marijuana, cocaine or other recreational drugs?
__ No
__ Yes, please describe:

Do you feel safe in your home?
__ Yes
__ No, please explain:

Do you have a history of abuse?
__ No
__ Yes, please describe:

Marital status:
__ Single
__ Married
__ Partnered
__ Separated
__ Divorced
__ Widowed

Review of Systems

Do you have any of the following (check all that apply)?

__ Fever
__ Palpitations
__ Dizziness
__ Anxiety
__ Shortness of breath
__ Incontinence
__ Painful intercourse
__ Cough
__ Urinary frequency
__ Joint pain
__ Vision changes
__ Constipation
__ Rash
__ Hearing loss
__ Diarrhea
__ Hot/cold intolerance
__ Weight changes
__ Chest pain
__ Headaches
__ Depression

Care Team / Chaperone

Would you like your provider to have another team member present during your exam today? __Yes __No __No preference