Weill Cornell Medicine
Obstetrics & Gynecology

New Patient Intake Form

Please complete this brief history to assist me in providing you with the best care possible.
This form will be added to your medical record.

Name: _____ Preferred Name _____ Preferred Pronoun(i.e. she/he; her/him) _____

Date of Birth: 0 Who referred you? _____

Reason for visit: _____

Sexuality/Gender Identity

What is your sexual orientation?
- ☐Straight/Heterosexual
- ☐Lesbian/Gay
- ☐Bisexual
- ☐Other _____
- ☐Decline to state

What sex were you assigned at birth?
- ☐Female
- ☐Male
- ☐Decline to state

What is your gender identity?
- ☐Female
- ☐Transgender woman/Transwoman
- ☐Male
- ☐Transgender man/Transman
- ☐Gender queer/Gender non -conforming
- ☐Decline to state

Recent Exam

Type of exam	Date of last exam	Location of exam
Pap test		
Mammogram		
Colonoscopy		
Pelvic/Transvaginal ultrasound		
Bone density study		

Gynecologic History

Date of last menstrual period: _____

Age (years) at 1st period _____; My period usually occurs every_____ days and lasts for _____days; Age at Menopause_____

Do you have a history of (If yes please provide date and describe):

- ☐ Ovarian cysts _____
- ☐ Fibroids _____
- ☐ Abnormal Pap test _____
- ☐ Sexually Transmitted Infection _____

Have you ever used oral contraceptives (if so for how many years)? _____

Have you ever used hormone replacement therapy (if so for how many years)? _____

Are you sexually active? ☐ No ☐ Yes Any problems? _____

Total number of pregnancies _____

# of Vaginal deliveries ___; Cesarean sections ___; Miscarriages ___; Abortions ___; Ectopic pregnancies ___;

Pregnancy Complications_____

Current Medications (include vitamins, herbs and other supplements)

Please review your attached medication list. Please add/remove medications based on what you currently take.

Name of Medication	Dosage	How Often

Allergies

Are you allergic to any medications? ☐ No ☐ Yes (Please specify the medication and reaction):

Medical History (either now or in the past/detail below with year of diagnosis and treatment given)

- ☐ Asthma
- ☐ Cancer
- ☐ Cardiac disease
- ☐ Diabetes
- ☐ Hypertension / high blood pressure
- ☐ Hyperlipidemia / cholesterol
- ☐ Irritable bowel syndrome
- ☐ Inflammatory bowel disease
- ☐ Lupus
- ☐ Osteoporosis / osteopenia
- ☐ Stroke
- ☐ Thrombotic disorder (blood clots)
- ☐ Thyroid disease (low / high)
- ☐ Reflux (GERD)

Psychiatric diagnosis
- ☐ Anxiety
- ☐ Depression
- ☐ Bipolar disorder
- ☐ Other: _____

_____

_____

Name: _____ Date of visit: _____

Surgical History

Name of Procedure	Date of Procedure	Reason for Procedure

Family History

Do you have a family member with any of the following cancers (if yes please list which family member and age of diagnosis)

- ☐ Breast cancer _____
- ☐ Ovarian cancer _____
- ☐ Uterine/endometrial cancer _____
- ☐ Prostate cancer _____
- ☐ Pancreatic cancer _____
- ☐ Colon cancer _____
- ☐ Melanoma _____
- ☐ Other cancer (specify) _____

Mother: ☐ Living ☐ Deceased (cause) _____

Father: ☐ Living ☐ Deceased (cause) _____

Siblings: Number living: _____ Number deceased: _____ Cause: _____

Social History

Do you exercise? If so what do you do _____

Occupation_____ Marital Status_____

Do you smoke? _____ How many packs a day? _____ If you quit, when was this? _____

Do you drink alcohol? _____ How many drinks per week? _____ Any other drugs? _____ Which other drugs?_ _____

Review of Systems: Are you experiencing any of the following symptoms?					
Constitutional	☐ No	☐ Weight loss	☐ Weight gain	☐ Fever	☐ Fatigue
Eye Problems	☐ No	☐ Vision Changes	☐ Glasses	☐ Contacts	☐ Other
Ear, Nose, Throat	☐ No	☐ Ulcers	☐ Sinusitis	☐ Headache	☐ Hearing Problems
Cardiovascular	☐ No	☐ Chest pain	☐ Leg Swelling	☐ Palpitations	☐ Other
Respiratory	☐ No	☐ Wheezing	☐ Cough	☐ Shortness of Breath	☐ Other
Gastrointestinal	☐ No	☐ Diarrhea	☐ Constipation	☐ Nausea	☐ Vomiting
Urinary	☐ No	☐ Painful Urination	☐ Urgency	☐ Frequency	☐ Bloody Urine
Skin/Breast	☐ No	☐ Breast Pain	☐ Nipple discharge	☐ Breast Mass	☐ Skin Rash
Neurological	☐ No	☐ Fainting	☐ Seizures	☐ Numbness	☐ Trouble Walking
Psychiatric	☐ No	☐ Depression	☐ Anxiety	☐ Other	
Blood/Lymph	☐ No	☐ Easy Bruising	☐ Abnormal Bleeding	☐ Swollen Glands	☐ Other
Musculoskeletal	☐ No	☐ Weakness	☐ Pain	☐ Other	

Physicians

Medical / primary care physician: _____ Phone #_____

Obstetrician / Gynecologist: _____ Phone # _____

Cardiologist: _____ Phone # _____

Other physician: _____ Phone # _____

Other physician: _____ Phone # _____