Weill Cornell Medicine
Obstetrics & Gynecology

MRN:_____

New Obstetrics Patient Intake Form

Answer all questions as they apply to you. This form will be added to your medical record.

Legal Last Name: _____ Legal First Name: _____
Who referred you? _____ Primary Care Provider: _____
Date of Birth: _____ Reason for visit: _____

Menstrual History

Date of last menstrual period: _____ Age (yrs) at 1st period:_____ Age at Menopause:_____
My period usually occurs every _____ days and lasts for _____days.

Please check No or Yes

Heavy Periods: ☐ No ☐ Yes Painful Periods: ☐ No ☐ Yes Irregular Bleeding: ☐ No ☐ Yes PMS (bloating, moody): ☐ No ☐Yes

Genetic History

Ethnic Background: _____ Partner's Age & Ethnic Background: _____

Has anyone in your family or your partner's family had any of the following? If so, please include which family member(s).

Autism_____ Mental Retardation_____
Birth Defect _____ Muscular Dystrophy _____
Congenital Heart Disease_____ Open Spine (Bifida) _____
Cystic Fibrosis _____ Sickle Cell Anemia_____
Down's syndrome_____ Thalassemia_____
Hemophilia_____ Unexplained Fetal Loss_____
Huntington's disease_____ Other_____

Gynecologic History

Last Pap smear: _____ Abnormal Pap Smears: ☐ No ☐Yes (Year & Treatment given) _____
Last Mammogram: _____ Abnormal Mammograms: ☐ No ☐ Yes (Year & Treatment given) _____

Have you ever had any of the following infections? (Please check all that apply).

☐Gonorrhea ☐ Chlamydia ☐Herpes ☐Trichomonas ☐Genital Warts/HPV ☐ Syphilis ☐None

If so, when and how was it treated? _____

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

☐Uterine Fibroids ☐ Infertility ☐ Ovarian Cysts ☐ Breast disease/biopsy Endometriosis ☐ None

If so, please detail year and how it was treated? _____

Contraception/Pregnancy History

Sexually active: ☐ No ☐ Yes Medical issues pertaining to sexual activity: _____
Current method of preventing pregnancy: _____
Total number of: pregnancies _____Vaginal deliveries _____ C-Section _____ Miscarriages _____Abortions _____ Ectopic _____
Pregnancy Complications: _____

Would you accept a blood transfusion in a life threatening situation? ☐NO ☐ YES

Pregnancy History

Date	Delivery Type	Birth Weight	Gender/Name	Complication

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*** **ALLERGIES:** ☐ **No** ☐ **Yes** **Please list allergies:** _____

Medications: (List names and dosages; include vitamins, herbs, and other supplements):

Medication	Dosage	How Often	Medication	Dosage	How Often

Past and Current Medical History (Please include year if diagnosis and treatment were given).

_____Anemia (Blood Transfusion?)	_____Hemorrhoids	_____Neurologic Disorder
_____Anesthesia Complications	_____ Hiatal Hernia	_____Psychiatric Disorder
_____Breast disease	_____Kidney Stones	_____Seizure Disorder/Epilepsy
_____Congenital Heart Problem	_____Lung Disease/Asthma	_____Sickle Cell/Carrier
_____Diabetes	_____Lupus	_____TB/ Positive PPD
_____Gastrointestinal/Gallstones	_____Migraine Headaches	_____Thrombotic Disorder (Blood Clots)

Surgical History (Briefly include your surgical history).

_____

Family History

Mother: ☐Living ☐Deceased (Cause):_____ Father: ☐Living ☐Deceased (Cause)_____

Siblings: Number Living: Number deceased: Deceased (Cause)

Detail below if anyone in your immediate family had the diagnosis: (Please indicate Mother, Father, Sibling, Grandparent(and which side).

Bleeding Disorder	Cancer-Other	High Blood Pressure	Neurological Disease
_____ Blood Clots	_____ Diabetes	_____ High Cholesterol	_____ Psychiatric Disease
_____ Cancer: Breast/GYN	_____ Heart Disease	_____ Multiple Pregnancy	_____ Thyroid Disease
Other_____			

Social History

Occupation: Marital Status: Do you smoke?☐ No ☐Yes If so, how many packs a day? ___

Do you drink alcohol? ☐ No ☐ Yes If so, how many drinks/week?____ Do you take drugs?☐ No☐ Yes If so, which ones?_____

Review of Systems: Are you experiencing any of the following symptoms? Please indicate all that apply or NO if they do not.

Constitutional	☐No	☐ Fatigue	☐ Weight Loss	☐ Weight Gain	☐ Fever
Eye Problems	☐No	☐ Vision Changes	☐ Glasses/Contacts		
Ear, Nose, Throat	☐No	☐ Headache	☐ Sinusitis	☐ Ringing in Ears	☐ Nose Bleed
Cardiovascular	☐No	☐ Shortness of Breathe	☐ Chest Pain	☐ Edema	☐ Palpitations
Respiratory	☐No	☐ Wheezing	☐ Coughing Blood	☐ Cough	
Gastrointestinal	☐No	☐ Nausea/vomiting	☐ Constipation	☐ Diarrhea	☐ Bloody Stool
Genitourinary	☐No	☐ Bloody Urine	☐ Painful Urination	☐ Urgency	☐ Frequency
Musculoskeletal	☐No	☐ Muscle Weakness	☐ Muscle Pain		
Skin/Breast	☐No	☐ Breast Pain	☐ Nipple Discharge	☐ Breast Mass	☐ Skin Rash
Neurological	☐No	☐ Fainting	☐ Seizures	☐ Numbness	☐Trouble Walking
Psychiatric	☐No	☐ Depression	☐ Anxiety		
Endocrine	☐No	☐ Dry skin	☐ Abnormal Thirst	☐ Hot Flashes	
Blood/Lymph	☐No	☐ Easy Bruising	☐Abnormal Bleeding	☐Swollen Glands	

Other _____

Reviewed By: _____**, MD on** _____**.**
Date

May 2020