Weill Cornell Medicine
Obstetrics & Gynecology

New Obstetrics Patient Intake Form

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

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

Gynecologic History:

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

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

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