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.

Please select your physician:

o **Dr. John Ilagan** o **Dr. Robin Kalish** o **Dr. Inna Landres** o **Dr. Malavika Prabu**
o **Dr. Shai Pri-Paz** o **Dr. Laura Riley** o **Dr. Georges Sylvestre** ○ **Dr. Emilie Vander Haar**

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 circle 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: Cause: _____

Detail below if anyone in your immediate family had the diagnosis: (Please indicate Mother, Father, Sibling, Grandparents 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? If so, how many packs a day?

Do you drink alcohol? No Yes If so, how many drinks/week? Do you take drugs? 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