New England Reproductive Medicine and Surgery LLC

Female Intake Form

Name: _____ **Date of birth:** _____

Address: _____

Phone: (H) _____ **(C)** _____

Email: _____

Primary Care Provider: _____ **GYN:** _____

Preferred Pharmacy: _____ **Address:** _____

Insurance: _____ **Member ID#:** _____

Partner's Name: _____

Medications/supplements. List Name(s) and Dosage below. Attach additional sheet if necessary.

_____

_____

_____

_____

Allergies. List Name(s) and Reactions below. Attach additional sheet if necessary.

_____

_____

_____

_____

Social History: (select one) ____ Married ____ Partner ____ Single ____ Divorced

Are you safe? ____ Yes ____ No

Who do you live with?

_____

What do you do for exercise?

_____

What do you do for work?

_____

What tobacco/nicotine products do you use?

_____

Did you use tobacco/nicotine products in the past? ____ Yes; When? _____ ____ No

Do you drink alcohol? ____ Yes; How often? _____ ____ No

What other drugs do you use?

_____

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Mental health history:
Do you/did you experience anxiety?
____ Yes; What treatments?
_____
____ No
Do you/did you experience depression?
____ Yes; What treatments?
_____
____ No
Do you/did you experience mood issues?
____ Yes; What treatments?
_____
____ No
Were you hospitalized for anxiety, depression and/or mood issues? ____ Yes ____ No

Family history:
Mom Alive? ____ Yes ____ No; Age at death: _____
Mom's Medical history:
_____

Dad Alive? ____ Yes ____ No; Age at death: _____
Dad's Medical history:
_____

Mother's Mother Alive? ____ Yes ____ No; Age at death: _____
Mother's Mother's Medical history:
_____

Mother's Father Alive? ____ Yes ____ No; Age at death: _____
Mother's Father's Medical history:
_____

Father's Mother Alive? ____ Yes ____ No; Age at death: _____
Father's Mother's Medical history:
_____

Father's Father Alive?____ Yes ____ No; Age at death: _____
Father's Father's Medical history:
_____

Sister(s) Alive? ____ Yes ____ No; Age at death: _____
Sister(s) Medical history:
_____

Brother(s) Alive? ____ Yes ____ No; Age at death: _____

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Brother(s) Medical history:
_____

Daughter(s) Alive? ____ Yes ____ No; Age at death: _____
Daughter(s) Medical history:
_____

Son(s) Alive? ____ Yes ____ No; Age at death: _____
Son(s) Medical history?
_____

Surgical history: attach additional sheet if necessary
_____
_____
_____
_____
_____
_____

Medical problems: attach additional sheet if necessary
_____
_____
_____
_____
_____
_____
_____
_____

Gynecological history:
First period occurred at _____ years old
Date of last period: _____
Cycles are: ____ regular ____ irregular
Cycle length is: ____ 28-30 days ____ >30 days ____ <28 days
Cycle flow is: ____ light ____ heavy
Pain with: ____ periods ____ sex ____ urination ____ BMs ____ other:
_____
History of: ____ endometriosis ____ cysts ____ fibroids ____ pelvic inflammatory disease
____ sexually transmitted infections
Pregnancy, number of: pregnancies ____ living children ____ full term births ____ premature births ____
stillbirths ____ c-section(s) ____ spontaneous miscarriage(s) ____ therapeutic abortion(s) ____