Women's Health Specialists
Women's Health Center
Intake Questionnaire

Legal Name:
Date of Birth:

Preferred Name:
Preferred Pronouns:
Age:

Legal Sex (Circle one)* **Male / Female**
While we recognize a number of genders/sexes, many insurance companies and legal entities do not. Please know that the name/sex listed on your insurance must be used on documents pertaining to insurance, billing & correspondence. If your preferred name/ pronouns are different than your legal name/pronoun, please let us know.

What is your Gender?

Name of Referring Provider:
Name of Primary OB/GYN:
Would you like us to share your records with the above providers YES?/NO

Please help us understand your medical history by answering the following questions:

Yes	No	Have you ever experienced (select all that apply):
		Heart problems
		Asthma or lung problems
		Kidney problems
		Blood clot in the legs/lungs
		Anemia or bleeding disorder
		Diabetes
		Seizures
		Migraines
		Depression, anxiety or bipolar disorder
		Breast Disease
		Other problems that you see a doctor for?
If YES, please describe these other medical problems:		

Yes	No	Do you have a family history of (select all that apply):
		Problems with Anesthesia
		History of Blood Clot in Legs or Lungs
		History of Bleeding Disorders
		History of Genetic Disorders
		History of Cancer (breast/ovarian/uterine)

Yes	No	
		Do you feel safe at home?
		Has anyone recently hurt or threatened you?
		Do you drink alcohol daily or more than 3 alcoholic drinks at a time?
		Have you smoked cigarettes within the last year?
Have you used <u>any</u> of these drugs in the last 3 years?		
		Meth, cocaine, crack, heroin or any other illegal drugs?
		Narcotic pain pills

Yes	No	Have you ever had surgery?
If yes, please describe the type of surgery and date:		

How many pregnancies have you had?	
	Number of vaginal deliveries
	Number of C-sections
	Number of miscarriages
	Number of abortions
	Number of ectopic, tubal, molar or other abnormal pregnancies

Menstrual History	
	Menarche (age at first period)
	Duration of period (in days)
	Frequency of cycle

Yes	No	Have you ever experienced
		Heavy Periods
		Painful Periods
		Bleeding inbetween periods

Yes	No	Have you ever had any of the following?
		Gonorrhea
		Chlamydia
		Genital Warts
		Genital Herpes
		Pelvic inflammatory disease (PID)
		Other sexually transmitted disease
		Abnormal pap smear
		When was your last pap smear?
		When were you last tested for HIV?
What was the result of the HIV test? (please circle one) **Negative/Positive/Don't Know**		
		Did you receive 3 doses of the HPV vaccine? (Gardasil)

Yes	No	Have you ever stayed overnight in a hospital, other than for deliveries or surgeries?
If yes, please describe why you had to stay in the hospital:		

Yes	No	Are you experiencing any:
		Fever / Chills
		Headaches/Vision Changes
		Chest pain/Palpitations
		Wheezing / Shortness of Breath
		Abdominal Pain / Cramping
		Painful Urination

Yes	No	Are you experiencing any:
		Vaginal Bleeding
		Vaginal/Pelvic Pain
		Abnormal Vaginal Discharge
		Nausea/Vomiting
		Depressive Symptoms
		Anxiety Symptoms

Yes	No	
		Are you **allergic** to any medications (please list)
		Are you allergic to **latex**?

What was the first day of your last menstrual period?	

Please list any **medications** that you have taken within the last month:

What birth control methods have you **used in the past**? (please circle)

Pills	Shot (Depo-Provera)	IUD
Patch (Ortho-Evra)	Morning after pill (Plan B, Ella)	Diaphragm
Vaginal Ring (Nuva Ring)	Implant (Implanon, Nexplanon, Norplant)	Condoms

What birth control methods **are you interested in today**? (please circle)

Pills	Shot (Depo-Provera)	IUD
Patch (Ortho-Evra)	Morning after pill	Diaphragm
Vaginal Ring (Nuva Ring)	Implant (Implanon, Nexplanon, Norplant)	Condoms

Reason for this termination (check all that apply):	
Do not desire pregnancy	
Incomplete miscarriage, fetal anomaly, or fetal death	
Rape/Assault	
Concerns about your health	
Other (please describe):	

Do you feel you need help in making a decision about whether to have an abortion or continue your pregnancy?
Yes **No**

Do you feel supported in your decision today?
Yes **No**

Do you have any concerns regarding the confidentiality of your visit today?
Yes **No**

Some patients want to see their ultrasound, while others do not. We are happy to do either for you. If you have an ultrasound done today, would you like the opportunity to view it?
Yes **No**

Some patients prefer not to know if the doctor finds anything unusual or abnormal about this pregnancy, such as if there are twins or if there is a problem with the pregnancy. If the doctor finds anything unusual or abnormal, would you like to be told about it?
Yes **No**

For some early pregnancies, medications can be used to cause cramping and bleeding to pass the pregnancy at home. Would you be interested in this option instead of a surgical abortion (also called a D&C)?
Yes **No** **Maybe**

Patient signature: ____ Date:__________________

Reviewed by:____ Date: __________________