IF YOU HAVE NOT COMPLETED THIS PAPERWORK IN THE WAITING ROOM,PLEASE COMPLETE AND GIVE TO YOUR NURSE. THANK YOU

University of Tennessee Graduate School of Medicine
UT OB/GYN Center
PATIENT INTAKE FORM

Today's Date: _____

Name: _____ **Preferred Name**: _____

DOB: _____ **Sexual Orientation:** _____

Reason for Visit Today: _____

Allergies: List any allergies to medications and the reaction experienced (rash, throat swelling, etc)

Medication	Reaction you have

Current Medications: If you have additional medications, please write on the back of this page

Medication Name	**Dose** (mg amount)	How often

Social History

Occupation: _____ Employer: _____

Relationship Status: _____ Do you feel safe in your current relationship? ☐ No ☐ Yes

Have you ever used tobacco/vaping products ☐ Yes ☐ No	Do you drink alcohol? ☐ Yes ☐ No
Have you ever used any recreational or IV drugs? (Ex:marijuana, cocaine, pills) ☐ Yes ☐ No	Do you currently use any recreational or IV drugs? ☐ Yes ☐ No
Do you exercise? ☐ NEVER ☐ RARELY ☐ 1-2x WEEKLY ☐ 3-5x WEEKLY ☐ DAILY	
Do you wear a seatbelt? ☐ NEVER ☐ OCCASIONALLY ☐ ALWAYS	
History of Physical abuse? ☐ Yes ☐ No	History of Sexual abuse? ☐ Yes ☐ No
Would you accept blood or blood products in an emergency? ☐ Yes ☐ No	

Gynecologic History

Age at first period?	Date of first day of your last period:
How would you describe your periods? ☐ Regular ☐ Irregular ☐ Painful ☐ Heavy ☐ I no longer have periods	
How many days do you bleed?_____	How many days are between your periods?_____
Are you currently sexually active? ☐ Yes ☐ No With a: ☐ male ☐ female	
Have you ever had an abnormal Pap smear? ☐ Yes ☐ No	
Current birth control method?	Are you happy with this method? ☐ Yes ☐ No
Have you experienced any of the following? ☐ Chlamydia ☐ Herpes ☐ Gonorrhea ☐ Syphilis ☐ Genital Warts ☐ Trichomoniasis	
Are you interested in screening for sexually transmitted infections today? ☐ Yes ☐ No	

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Name: _____ **DOB**: _____

Obstetric History

How many times in your life have you been pregnant? (Include miscarriages and abortions) _____

Please list information below about your previous pregnancies. List additional pregnancies on the back of this page.

Pregnancy	Year	Type of delivery: (C-section, miscarriage, etc.)	Weeks pregnant?	Baby weight	Any Complications?
1st					
2nd					
3rd					
4th					

Please list your **Primary Care Provider**:_____

Please list any other doctors that you follow and their specialty:

Past Medical History: Please list any medical problems you have or have been treated for in the past.

Problem	**Year**

Surgical History: Please list any surgeries you have had and the year that it was performed.

Surgery	**Year**

Family History: Have any of the following occurred in a family member? If so, please indicate who (Ex: Parents, Grandparents,etc..)

Condition	**Family Member**	**Condition**	**Family Member**
Breast cancer		High Blood Pressure	
Colon cancer		Diabetes	
Ovarian cancer		Blood clots	
Uterine cancer		Birth defect	
Stroke or heart attack		Fibroids	
Endometriosis		Other:	

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Name: _____ **DOB**: _____

Screening Questions:

Y	N	Have you ever had:	Date
☐	☐	DEXA (Bone Scan for Osteoporosis)	
☐	☐	Mammogram	
☐	☐	Colonoscopy	
☐	☐	Pap Smear	
☐	☐	Flu Vaccine	
☐	☐	Pneumococcal Vaccine	
☐	☐	HPV Vaccine (Gardasil, Cervarix)	
☐	☐	TDAP Vaccine	
☐	☐	Do you have a living will or advance directive?	

Are you up to date on vaccinations? ☐ Yes ☐ No ☐ Not sure

Have you had your **Covid-19 vaccines**? ☐ **Yes** ☐ **No** (If Yes which one) ☐ **Pfizer** ☐ **Moderna** ☐ **J& J** **Dates:** _____

Review of Systems: Please check any symptoms you are **CURRENTLY** experiencing:

Y	N	**General**
☐	☐	Feeling tired
☐	☐	Difficulty sleeping
☐	☐	Fever/Chills
Y	**N**	**Gastrointestinal**
☐	☐	Nausea/Vomiting
☐	☐	Diarrhea
☐	☐	Blood in stool
☐	☐	Change in bowels
Y	**N**	**Psych**
☐	☐	Anxiety
☐	☐	Depression
Y	**N**	**Endocrine**
☐	☐	Heat/cold intolerance
☐	☐	Excessive thirst
☐	☐	Excessive urination

Y	N	**Cardiothoracic/Respiratory**
☐	☐	Chest pain
☐	☐	Heart racing
☐	☐	Swelling
☐	☐	Cough
☐	☐	Trouble breathing
Y	**N**	**Gynecologic**
☐	☐	Abnormal discharge
☐	☐	Vaginal itching
☐	☐	Pelvic pain
☐	☐	Vaginal dryness
☐	☐	Bleeding after intercourse
☐	☐	Pain with intercourse
☐	☐	Vaginal odor
☐	☐	Vaginal or vulvar sores
☐	☐	Abnormal bleeding

Y	N	**Breast**
☐	☐	Rash
☐	☐	Nipple discharge
☐	☐	Breast pain
☐	☐	Breast lump
Y	**N**	**Urinary**
☐	☐	Pain with urination
☐	☐	Increased frequency of urination
☐	☐	Blood in urine
☐	☐	Trouble emptying bladder

Submit Form