Bella
OBSTETRICS & GYNECOLOGY

New Patient Intake Form Date: _____

Name: _____ DOB: _____

Preferred name: _____ Occupation: _____

Marital status: _____ Spouse name: _____

Gynecological history

	Answer	Do you have a history of:	Yes/No
Last menstrual period		Uterine fibroids?	
Age periods began		Endometriosis?	
How long do periods last?		Ovarian cysts?	
Painful? Heavy?		Abnormal vaginal discharge?	
Current birth control		Sexually transmitted diseases?	

Wellness History

Last pap smear: normal/abnormal	Date of last pap smear:
History of abnormal pap? Y/N	Any treatment done?
Gardasil vaccine? Y/N	Sexually active? Y/N
Last mammogram:	Last bone density scan:
Last colonoscopy:	Sexual orientation:

Obstetrical History

Total #pregnancies: _____ Full term: _____ Preterm: _____ Miscarriages/Abortions: _____

Living children: _____

Past Pregnancy Details

	Delivery Date	Gestational Age	Weight	Vaginal/C-section	Complications
1					
2					
3					
4					
5					

Social History

Tobacco use? Y/N	If yes, how many packs per day? Years?
Alcohol use? Y/N	If yes, how often?
Drug use? Y/N	If yes, what type? How often?

Medications- please list all medications and dosage information

Medication name	Dosage	Frequency

Allergies (please list reaction): _____

Past Medical History

Medical history	Please check if applicable	If Yes, please explain
Abnormal hair growth		
Asthma/lung disease		
Autoimmune disease		
Blood clots in legs/lungs		
Blood transfusion		
Bowel problems		
Breast issues/pain		
Breast Cancer		
Cancer		
Depression/Anxiety		
Diabetes		
Heart problems		
High blood pressure		
High cholesterol		
Involuntary loss of urine		
Kidney stones/infections		
Migraines		
Seizures		
Stroke		
Thyroid disease		
Weight loss/gain		

Other medical history: _____

_____

Past Surgical History

Surgery	Date
1	
2	
3	
4	
5	
6	

Past Hospitalizations (excluding childbirth)

Why were you hospitalized?	Date
1	
2	
3	

Family History

Mother Age _____ Living _____ Deceased _____ Age/cause of death _____

Father Age _____ Living _____ Deceased _____ Age/cause of death _____

Siblings # _____ Medical issues _____

Children # _____ Medical issues _____

Do members in your family have:	Please check if applicable	Please explain
Autoimmune Disease		
Birth defects		
Blood clots legs/lungs		
Breast Cancer		
Colon Cancer		
Cystic Fibrosis		
Diabetes		
Heart issues		
High blood pressure		
High cholesterol		
Ovarian Cancer		
Sickle Cell Disease		
Stroke		
Uterine Cancer		

Other family history_____

_____

Review of Systems

Please circle if you are ***currently*** experiencing any of the following:

General:	☐ fever	☐ chills	☐ weight loss/weight gain	
Head/Ears/Nose/Throat:	☐ headaches	☐ ear pain	☐ runny nose	☐ sore throat
Cardiovascular:	☐ chest pain	☐ racing heart	☐ irregular heartbeat	
Respiratory:	☐ wheezing	☐ cough	☐ shortness of breath	
Gastrointestinal:	☐ nausea	☐ vomiting	☐ diarrhea	☐ constipation ☐ abdominal pain
Breast:	☐ breast lumps	☐ breast pain	☐ skin changes	☐ nipple discharge
Skin:	☐ rash	☐ acne	☐ new skin lesions	
Neurologic:	☐ numbness	☐ tingling	☐ headaches	
Musculoskeletal:	☐ joint pain	☐ joint swelling		
Endocrine:	☐ hair loss	☐ intolerance to heat/cold	☐ abnormal hair growth	

Primary Care Physician

Name: _____

Address/Phone number: _____

Who referred you/how did you hear about our practice? _____

Reason for visit:

_____

_____

_____

_____

_____

_____