Patient Addressograph

FOR OFFICE USE ONLY
NEW PATIENT
ESTABLISHED PATIENT
CONSULTATION
REPORT SENT: / /

Ko'olau Women's Healthcare, Inc.
642 Ulukahiki St, #209 Kailua, HI 96734
Phone: 808-230-8500 Fax: 808-230-8501

PATIENT INTAKE HISTORY

PATIENT NAME:	BIRTH DATE: / /	DATE: / /
REFERRED BY:		
WHY HAVE YOU COME TO THE OFFICE TODAY?		
IF YOU ARE HERE FOR AN ANNUAL EXAMINATION IS THIS A PRIMARY CARE VISIT OR GYNECOLOGY ONLY		
IS THIS A NEW PROBLEM?		
PLEASE DESCRIBE YOUR PROBLEM, INCLUDING WHERE IT IS, HOW SEVERE IT IS, AND HOW LONG IT HAS LASTED.		

If you are uncomfortable answering any questions, leave them blank; you can discuss them with your doctor or nurse.

American College of Obstetricians and Gynecologists

GYNECOLOGIC HISTORY

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	PHYSICIAN'S NOTES
LAST NORMAL MENSTRUAL PERIOD (FIRST DAY): / /	
AGE PERIODS BEGAN:	
LENGTH OF PERIODS (NUMBER OF DAYS OF BLEEDING):	
NUMBER OF DAYS BETWEEN PERIODS:	
ANY RECENT CHANGES IN PERIODS?	
ARE YOU CURRENTLY SEXUALLY ACTIVE?	
HAVE YOU EVER HAD SEX?	
NUMBER OF SEXUAL PARTNERS (LIFETIME):	
SEXUAL PARTNERS ARE MEN WOMEN BOTH	
PRESENT METHOD OF BIRTH CONTROL:	
HAVE YOU EVER USED AN INTRAUTERINE DEVICE (IUD) OR BIRTH CONTROL PILLS?	
IF YES, FOR HOW LONG?	
WHEN WAS YOUR LAST PAP TEST?	
WHAT WAS THE RESULT?	
HAVE YOU EVER HAD AN ABNORMAL PAP TEST?	
DO YOU DO BREAST SELF-EXAMINATIONS?	
HAVE YOU BEEN EXPOSED TO DIETHYLSTILBESTROL (DES)?	

PATIENT INTAKE HISTORY *(Continued)*

PATIENT NAME:	BIRTH DATE: / /	ID NO.:	DATE: / /

OBSTETRIC HISTORY

	NUMBER		NUMBER		NUMBER
PREGNANCIES		ABORTIONS		MISCARRIAGES	
PREMATURE BIRTHS (<37 WEEKS)		LIVE BIRTHS		LIVING CHILDREN	

NO.	BIRTH DATE	WEIGHT AT BIRTH	BABY'S SEX	WEEKS PREGNANT	TYPE OF DELIVERY (VAGINAL, CESAREAN, ETC.)	PHYSICIAN'S NOTES
1.						
2.						
3.						
4.						

ANY PREGNANCY COMPLICATIONS?

DIABETES HYPERTENSION/HIGH BLOOD PRESSURE PREECLAMPSIA/TOXEMIA OTHER

ANY HISTORY OF DEPRESSION BEFORE OR AFTER PREGNANCY? NO YES, HOW TREATED

CURRENT MEDICATIONS

(Including hormones, vitamins, herbs, nonprescription medications)

DRUG NAME	DOSAGE	WHO PRESCRIBED	DRUG NAME	DOSAGE	WHO PRESCRIBED

FAMILY HISTORY

MOTHER: LIVING DECEASED—CAUSE: AGE: | FATHER: LIVING DECEASED—CAUSE: AGE:

SIBLINGS: NUMBER LIVING: NUMBER DECEASED: CAUSE(S)/AGE(S):

CHILDREN: NUMBER LIVING: NUMBER DECEASED: CAUSE(S)/AGE(S):

ILLNESS	YES	WHICH RELATIVE(S) AND AGE OF ONSET	PHYSICIAN'S NOTES
DIABETES			
STROKE			
HEART DISEASE			
BLOOD CLOTS IN LUNGS OR LEGS			
HIGH BLOOD PRESSURE			
HIGH CHOLESTEROL			
OSTEOPOROSIS (WEAK BONES)			
HEPATITIS			
HIV/AIDS			
TUBERCULOSIS			
BIRTH DEFECTS			
ALCOHOL OR DRUG PROBLEMS			
BREAST CANCER			
COLON CANCER			
OVARIAN CANCER			
UTERINE CANCER			
MENTAL ILLNESS/DEPRESSION			
ALZHEIMER'S DISEASE			
OTHER			

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PATIENT INTAKE HISTORY *(Continued)*

PATIENT NAME:	BIRTH DATE: / /	ID NO.:	DATE: / /

SOCIAL HISTORY

	YES	NO	PHYSICIAN'S NOTES
EVER SMOKED? CURRENT SMOKING: PACKS PER DAY: YEARS:			
ALCOHOL: DRINKS PER DAY: DRINKS PER WEEK: TYPE OF DRINK:			
DRUG USE			
SEAT BELT USE			
REGULAR EXERCISE: HOW LONG AND HOW OFTEN?			
DAIRY PRODUCT INTAKE AND/OR CALCIUM SUPPLEMENTS: DAILY INTAKE:			
HEALTH HAZARDS AT HOME OR WORK?			
HAVE YOU BEEN SEXUALLY ABUSED, THREATENED, OR HURT BY ANYONE?			
DO YOU HAVE AN ADVANCE DIRECTIVE (LIVING WILL)?			
ARE YOU AN ORGAN DONOR?			

PERSONAL PROFILE

SEXUAL ORIENTATION: HETEROSEXUAL HOMOSEXUAL BISEXUAL

MARITAL STATUS: MARRIED LIVING WITH PARTNER SINGLE WIDOWED DIVORCED

NUMBER OF LIVING CHILDREN:

NUMBER OF PEOPLE IN HOUSEHOLD:

SCHOOL COMPLETED: HIGH SCHOOL SOME COLLEGE/AA DEGREE COLLEGE GRADUATE DEGREE OTHER

CURRENT OR MOST RECENT JOB:

TRAVEL OUTSIDE THE UNITED STATES? LOCATION(S):

PERSONAL PAST HISTORY OF ILLNESSES

MAJOR ILLNESSES	YES (DATE)	NO	NOT SURE	PHYSICIAN'S NOTES
ASTHMA				
PNEUMONIA/LUNG DISEASE				
KIDNEY INFECTIONS/STONES				
TUBERCULOSIS				
FIBROIDS				
SEXUALLY TRANSMITTED DISEASE/CHLAMYDIA				
INFERTILITY				
HIV/AIDS				
HEART ATTACK/DISEASE				
DIABETES				
HIGH BLOOD PRESSURE				
STROKE				
RHEUMATIC FEVER				
BLOOD CLOTS IN LUNGS OR LEGS				
EATING DISORDERS				
AUTOIMMUNE DISEASE (LUPUS)				
CHICKENPOX				
CANCER				
REFLUX/HIATAL HERNIA/ULCERS				
DEPRESSION/ANXIETY				
ANEMIA				
BLOOD TRANSFUSIONS				
SEIZURES/CONVULSIONS/EPILEPSY				
BOWEL PROBLEMS				
GLAUCOMA				
CATARACTS				
ARTHRITIS/JOINT PAIN/BACK PROBLEMS				
BROKEN BONES				
HEPATITIS/YELLOW JAUNDICE/LIVER DISEASE				
THYROID DISEASE				

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PATIENT INTAKE HISTORY *(Continued)*

PATIENT NAME:	BIRTH DATE: / /	ID NO.:	DATE: / /

PERSONAL PAST HISTORY OF ILLNESSES *(Continued)*

MAJOR ILLNESSES	YES (DATE)	NO	NOT SURE	PHYSICIAN'S NOTES
GALLBLADDER DISEASE				
HEADACHES				
DES EXPOSURE				
INFERTILITY				
BLEEDING DISORDERS				
OTHER				

OPERATIONS/HOSPITALIZATIONS

REASON	DATE	HOSPITAL

INJURIES/ILLNESSES

TYPE	DATE	TYPE	DATE

IMMUNIZATIONS/TEST

	DATE		DATE
TETANUS–DIPHTHERIA BOOSTER		INFLUENZA VACCINE (FLU SHOT)	
HEPATITIS A VACCINE		HEPATITIS B VACCINE	
VARICELLA (CHICKENPOX) VACCINE		PNEUMOCOCCAL (PNEUMONIA) VACCINE	
MEASLES–MUMPS–RUBELLA (MMR) VACCINE		TUBERCULOSIS (TB) SKIN TEST: RESULT:	

PHYSICIAN'S NOTE

REVIEW OF SYSTEMS

Please check (x) if any of the following symptoms apply to you now or since adulthood

	NOW	PAST	NOT SURE	PHYSICIAN'S NOTES
1. CONSTITUTIONAL				
WEIGHT LOSS				
WEIGHT GAIN				
FEVER				
FATIGUE				
CHANGE IN HEIGHT				

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PATIENT INTAKE HISTORY *(Continued)*

PATIENT NAME:	BIRTH DATE: / /	ID NO.:	DATE: / /

REVIEW OF SYSTEMS *(Continued)*

	NOW	PAST	NOT SURE	PHYSICIAN'S NOTES
2. EYES				
DOUBLE VISION				
SPOTS BEFORE EYES				
VISION CHANGES				
GLASSES/CONTACTS				
3. EAR, NOSE, AND THROAT				
EARACHES				
RINGING IN EARS				
HEARING PROBLEMS				
SINUS PROBLEMS				
SORE THROAT				
MOUTH SORES				
DENTAL PROBLEMS				
4. CARDIOVASCULAR				
CHEST PAIN OR PRESSURE				
DIFFICULTY BREATHING ON EXERTION				
SWELLING OF LEGS				
RAPID OR IRREGULAR HEARTBEAT				
5. RESPIRATORY				
PAINFUL BREATHING				
WHEEZING				
SPITTING UP BLOOD				
SHORTNESS OF BREATH				
CHRONIC COUGH				
6. GASTROINTESTINAL				
FREQUENT DIARRHEA				
BLOODY STOOL				
NAUSEA/VOMITING/INDIGESTION				
CONSTIPATION				
INVOLUNTARY LOSS OF GAS OR STOOL				
7. GENITOURINARY				
BLOOD IN URINE				
PAIN WITH URINATION				
STRONG URGENCY TO URINATE				
FREQUENT URINATION				
INCOMPLETE EMPTYING				
INVOLUNTARY/UNINTENDED URINE LOSS				
URINE LOSS WHEN COUGHING OR LIFTING				
ABNORMAL BLEEDING				
PAINFUL PERIODS				
PREMENSTRUAL SYNDROME (PMS)				
PAINFUL INTERCOURSE				
ABNORMAL VAGINAL DISCHARGE				
8. MUSCULOSKELETAL				
MUSCLE WEAKNESS				

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REVIEW OF SYSTEMS *(Continued)*

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	NOW	PAST	NOT SURE	PHYSICIAN'S NOTES
8. MUSCULOSKELETAL *(Continued)*				
MUSCLE OR JOINT PAIN				
9a. SKIN				
RASH				
SORES				
DRY SKIN				
MOLES (GROWTH OR CHANGES)				
9b. BREASTS				
PAIN IN BREAST				
NIPPLE DISCHARGE				
LUMPS				
10. NEUROLOGIC				
DIZZINESS				
SEIZURES				
NUMBNESS				
TROUBLE WALKING				
MEMORY PROBLEMS				
FREQUENT HEADACHES				
11. PSYCHIATRIC				
DEPRESSION OR FREQUENT CRYING				
ANXIETY				
12. ENDOCRINE				
HAIR LOSS				
HEAT/COLD INTOLERANCE				
ABNORMAL THIRST				
HOT FLASHES				
13. HEMATOLOGIC/LYMPHATIC				
FREQUENT BRUISES				
CUTS DO NOT STOP BLEEDING				
ENLARGED LYMPH NODES (GLANDS)				
14. ALLERGIC/IMMUNOLOGIC				
MEDICATION ALLERGIES				
IF ANY, PLEASE LIST ALLERGY AND TYPE OF REACTION:				
LATEX ALLERGY				
OTHER ALLERGIES				
PLEASE LIST ALLERGY AND TYPE OF REACTION:				

FORM COMPLETED BY: PATIENT OFFICE NURSE PHYSICIAN OTHER:

SIGNATURE OF PATIENT:

DATE REVIEWED BY PHYSICIAN WITH PATIENT: / /	PHYSICIAN SIGNATURE:

ANNUAL REVIEW OF HISTORY

DATE REVIEWED: / /	PHYSICIAN SIGNATURE:
DATE REVIEWED: / /	PHYSICIAN SIGNATURE:
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