Women's Health Patient Intake Form

Personal Information

Full Name

Date of Birth

Phone Number

Email Address

Address

Emergency Contact Name & Relationship

Emergency Contact Phone

Medical History

Allergies

Current Medications

Medical Conditions / Surgeries

Family Medical History

Gynecologic & Obstetric History

Age at First Period

Date of Last Period

Typical Cycle Length (days)

Gynecologic Conditions (e.g. PCOS, Endometriosis)

Number of Pregnancies

Number of Live Births

Number of Miscarriages

Current Contraception

Date of Last Pap Smear

Are you in menopause?

Other Information

Do you smoke?

Do you drink alcohol?

Reason for Visit