NANCY CARLSON FISHER, M.D.

PATIENT INTAKE HISTORY

Patient Name: _________________________Date__/__/__ Age____

GYNECOLOGIC HISTORY

- **Last menstrual period (first day) __/__/__**
- **Age periods started _______**
- **Number of days of bleeding _______**
- **Number of days between periods _______**
- **Any recent changes in periods? Y N**
- **Present method of birth control _____________________**
- **Have you ever used an IUD? Y N Dates__________**
- **Last PAP (date and result) _____________________**
- **History of an abnormal PAP Y N**
- **Do you perform self breast exams? Y N**
- **History of gynecologic surgery Y N**
- **History of hormone use current past never total yrs_____**
- **History of osteoporosis Y N**

OBSTETRICAL HISTORY

- **Pregnancies (total) __**
- **Term births __ Preterm(<37 wks) __ Abortions __**
  Miscarriages __ Living children __

	Birth Date	Weight	Sex	Weeks Pregnant	Delivery/Complications
1					
2					
3					
4					

MEDICATIONS (Please include vitamins and herbal supplements)

1. **5.**
2. **6.**
3. **7.**
4. **8.**

ALLERGIES Medications_______________________________________
Environmental_____________________________________
Latex Y N

TOBACCO Current Y N packs per day__ Number of years__
Past Y N packs per day__ Number of years__
Never

ALCOHOL Drinks per day__ Drinks per week__

Name____

PERSONAL PROFILE

Marital Status: Married Single Divorced Widowed Live w/partner
Education: High School College Graduate Degree
Travel outside U.S. Frequently Occasionally Rarely

PAST MEDICAL HISTORY

ILLNESS	No	Yes	Dates, Treatment, Active, Resolved
Migraines			
Seizures			
Glaucoma			
Thyroid Disease			
Breast Disease			
Cancer			
Asthma			
Lung Disease			
Heart Disease			
High Cholesterol			
High Blood Pressure			
Liver Disease			
Gallbladder Disease			
Diabetes			
Ulcers			
Bowel Disease			
Kidney Disease/Stone			
Incontinence			
Bladder Infections			
HIV/AIDS			
Anemia			
Eating Disorder			
Mental Illness			
Transfusion			
Broken Bones			

OPERATIONS

Operation	Date	Complications/Notes

Name:____

FAMILY HISTORY

ILLNESS	Y / N	Family Member/Age of Diagnosis
Ovarian Cancer		
Uterine Cancer		
Colon Cancer		
Breast Cancer		
Osteoporosis		
Diabetes		
Blood Clots		
High Blood Pressure		
High Cholesterol		
Stroke		
Heart Disease		
Cancer		
Birth Defects		
Depression		
Mental Illness/Alzheimer's		
Alcoholism		
Drug Abuse		

IMMUNIZATIONS

Vaccination	Date
Tetanus	
Hepatitis B Vaccine	
Varicella Vaccine	
Influenza Vaccine	

Signature____________________________________ **Date**__________________