CAROLINA ELITE WOMEN'S CARE INTAKE FORM CHART#__________

First Name:_____________________________ Last Name:_______________________________Date of Birth:_______________

Allergies:____
Current Medications and dosage:

____

____

GYN History: Please circle No or Yes

1st day of last period: (XX/XX/XXXX) _____/______/________	Date of last pap smear: (XX/XX/XXXX) _____/______/________	
Method you are currently using to prevent pregnancy:	History of abnormal pap smears: Yes / No	
How many days do you flow:	HPV vaccine: Yes / No	
Frequency of flow in days:	History of ovarian cysts: Yes / No	
Painful periods: Yes / No	History of fibroids: Yes / No	
Bleeding between periods: Yes / No	History of endometriosis: Yes / No	Are you planning pregnancy in the future? Yes / No

Obstetrical History: How many total pregnancies have you had? _____How many were: Full Term______, Premature ______, Miscarriages ______, Abortions ______

Past Pregnancies:

Date of Birth (XX/XX/XXXX)	Place	How many weeks?	Anesthesia	Duration of labor	Vaginal or c-section?	Baby(s) weight	Sex of baby	Complications

Family History: Indicate WHO and M (mothers' side) or F (fathers' side)

1. Cancer: TYPE? ____________________ WHO? ___________________ M/F SIDE ________
2. Diabetes: WHO? ___________________ M/F SIDE ________
3. Endometriosis: WHO? ___________________ M/F SIDE ________
4. Heart Disease/ Heart Problems before age of 55: WHO? ___________________ M/F SIDE ________
5. High Blood Pressure / Stroke: WHO? ___________________ M/F SIDE ________
6. Any other Major Medical problems: WHO? ___________________ M/F SIDE ________

Social History:

Diet & Exercise: please check the corresponding answer / box below

1. What type of diet are you following? Regular / Vegetarian / Vegan / Gluten free / Specific / Carbohydrate / Cardiac / Diabetic
2. What is your exercise level? None / Occasional / Moderate / Heavy
3. How many days of moderate to strenuous exercise, like a brisk walk, did you do in the last 7 days? ________

Activities of Daily Living: **Check the correct answer**

Question	YES	NO
Are you able to care for yourself?		
Are you blind or do you have difficulty seeing?		
Are you deaf or do you have serious difficulty hearing?		
Do you have difficulty concentrating, remembering or making decisions?		
Do you have difficulty walking or climbing stairs?		
Do you have difficulty dressing or bathing?		
Do you have difficulty doing errands alone?		
Are you able to walk? (If not please add your restrictions) ____		
Do you have transportation difficulties?		
What is the highest grade or level of school you have completed? _______________________________________		
Are you currently employed?		

Substance use- **circle and fill in the correct answer**

1. Do you or have you ever smoked tobacco? Never / Former smoker / current every day smoker / Current some day smoker
2. Do you or have you ever used any other forms of tobacco or nicotine? Yes / No
3. Date of your most recent tobacco screening: (XX/XX/XXXX) _________________
4. Level of alcohol consumption? None / Occasional / Moderate / Heavy
5. Do you use any illicit or recreational drugs? Yes / No
6. Level of caffeine consumption? None / Occasional / Moderate / Heavy

Advanced Directives

7. Do you have an advanced directive? Yes / No
8. Is blood transfusion acceptable in an emergency? Yes / No

Marriage and Sexuality

9. What is your relationship status? Unknown / Married / Single / Divorced / Separated / Widowed / Domestic Partnership / Other
10. Are you sexually active? Yes / No
11. How many children do you currently have? _______

Social History

12. Do you have a concern about a sexually transmitted disease or testing? Yes / No
13. Are you or any other member of your family in an abusive situation? Yes / No

Surgical History – please list all NON–PREGNANCY hospitalizations, surgeries, or outpatient surgeries:

Date (xx/xx/xxxx)	Place	Reason	Doctor

Medical History- please check the corresponding answer / box below

Are you being treated for any illness, condition or surgery by another physician? ____

Primary care provider: ______________________________

Date of last Mammogram ______________ Results: _____________________

Tetanus shot within the last 10 Years? Yes _____ Date: ____________ N0 _____

Have you had the FLU vaccine this year? Yes _____ Date: ____________ N0 _____

Have you had your cholesterol checked within the last 5 years? Yes:_____ Date: __________ Results: ________________ N0____

Have you had a colonoscopy? Yes: _____ Date: ____________ Results: ______________________ N0 _____

Have you had a bone density scan? Yes: _____ Date: ____________ Results: ______________________ N0 _____

Check if you currently have or ever had any of the following conditions:

❑ Abuse/Domestic Violence	❑ Blood Transfusion	❑ Heart Disease / Problems	❑ Migraines
❑ Anemia	❑ Breast Cancers	❑ High Blood Pressure	❑ Polycystic Ovarian Syndrome
❑ ART/IVF or FET	❑ Cancer (type?) __________	❑ High Cholesterol	❑ Seizures
❑ Asthma	❑ Chicken Pox	❑ History of HIV	❑ STD's
❑ Birth Defects or inherited disease	❑ Depression / Postpartum Depression	❑ History of Sickle Cell Anemia	❑ Stroke
❑ Blood clots in legs or lungs	❑ Diabetes	❑ Kidney or Bladder problems	❑ Thyroid Problems
❑ Blood Diseases	❑ Endometriosis	❑ Lung Disease	❑ Trauma / Violence

Other: ____

Patient signature: ___________________________________ **Date: __________________**

PHARMACY

Please add the pharmacy you'd like to have on file. Please fill out BOTH the name and address below. Thank you.

Name of Pharmacy: ____

Address of Pharmacy:

____

____

____

PATIENT PORTAL EMAIL

Please provide a preferred email address for access to your patient portal

____

PATIENT MAILING ADDRESS

____

____

____

HOW'D YOU HEAR ABOUT US?

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