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Medical Intake Form

Date: _____

Full Name: _____ Date of Birth: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Home phone number: _____ Mobile phone number: _____

Email: _____ Marital Status: ❒ Single ❒ Married ❒ Divorced ❒ Widowed

Employer: _____ Occupation: _____

Work phone: _____

Emergency Contact: Full Name: _____

Relationship: _____ Number: _____

How did you hear about our office? _____

Reason for today's visit? _____

Pharmacy: _____

❒ By checking this box, I agree to Vitality Women's Healthcare contacting me via email, text and phone.

Patient signature _____

Medical History:

Have you ever had any of the following?

High blood pressure	❒ Yes ❒ No	High cholesterol	❒ Yes ❒ No
Heart disease	❒ Yes ❒ No	Heart attack	❒ Yes ❒ No
Blood Clot / DVT / PE	❒ Yes ❒ No	Stroke	❒ Yes ❒ No
Thyroid disease	❒ Yes ❒ No	Diabetes (type) _____	❒ Yes ❒ No
Asthma / emphysema / COPD	❒ Yes ❒ No	Hepatitis A / B / C (type) _____	❒ Yes ❒ No
Kidney disease	❒ Yes ❒ No	Liver disease	❒ Yes ❒ No
Cancer (type) _____	❒ Yes ❒ No	Lupus	❒ Yes ❒ No
Bleeding disorders	❒ Yes ❒ No	Other _____	

Gynecology History:

Is it possible you are pregnant? ❒ Yes ❒ No Are you breast feeding? ❒ Yes ❒ No

Number of Pregnancies: _____ Number of births: _____ Number of miscarriages: _____

Number of abortions: _____ Number of ectopic: _____

Any complications with pregnancy? ❒ Yes ❒ No If yes, please explain _____

Number of c-sections: _____ Number of vaginal deliveries: _____

Date of last period: _____ Age of first period: _____

Age of menopause: _____

Heavy periods ❒ Yes ❒ No Irregular periods ❒ Yes ❒ No

Painful periods ❒ Yes ❒ No

Are you sexually active? ❒ Yes ❒ No ❒ Never Age of first intercourse? _____

Current method of birth control: ❒ None ❒ Condoms ❒ Pills ❒ Patch ❒ Nuva Ring ❒ Depo Injection ❒ Implant in arm

❒ IUD ❒ Tubal Sterilization ❒ Vasectomy in Partner ❒ Other ¨ _____

What medicines (prescription and over-the-counter), vitamins, supplements and herbs do you take (regularly and as needed)?

❒ None (skip this section)

Name	Dose	How often?	What is it for?

Do you often have trouble remembering to take medicines? ❒ Yes ❒ No

What surgeries have you had? ❒ None (skip this section)

Surgery	Date	What is it for?

Any drug / latex allergies? ❒ Yes ❒ No If yes, please list: _____

What skin care products are you currently using / applying? _____

Do you use sunscreen with SPF 30 or higher? ❒ Yes ❒ No

Which of the following bother you?

❒ Wrinkles	❒ Aging skin	❒ Brown spots	❒ Melasma	❒ Oily skin / acne
❒ Unwanted hair	❒ Redness	❒ Rosacea	❒ Unwanted tattoos	❒ Scars
❒ Moles	❒ Skin texture	❒ Enlarged pores	❒ Facial telangectasia / vessels	
❒ Weight	❒ Jowls	❒ Excess fat under chin		

Pap smear:

Date of last Pap Smear: _____ What was the result? ❒ Normal ❒ Abnormal

Have you had an abnormal pap in the past? ❒ Yes ❒ No If so, when? _____

Have you ever needed any of the following treatment(s) for an abnormal pap?

Colposcopy ❒ Yes ❒ No LEEP ❒ Yes ❒ No Cone Biopsy ❒ Yes ❒ No

Date of Last Mammogram: _____ ❒ Normal ❒ Abnormal ❒ Never had one

Date of Last Bone Density: _____ ❒ Normal ❒ Abnormal ❒ Never had one

Date of Last Colonoscopy: _____ ❒ Normal ❒ Abnormal ❒ Never had one

Do you smoke? ❒ Yes ❒ No, never ❒ In the past If Yes, how many packs per day? _____

If in the past, date quit: _____

Do you use electronic cigarette / vape? ❒ Yes ❒ No, never ❒ In the past

If yes, how many times a day: _____ If in past, date quit: _____

Do you drink Alcohol? ❒ Yes ❒ No, never ❒ In the past If yes, drinks per day / week / month: _____

If in the past, alcohol problem, date quit: _____

Have you taken illicit drugs? ❒ Yes ❒ No, never ❒ In the past

If yes, type: _____ If in the past, type and date quit: _____

Do you exercise? ❒ Yes ❒ No, never If yes, type and frequency: _____

Have you ever been diagnosed with any of the following Mental Health problems:

Depression	❒ Yes ❒ No	Bipolar	❒ Yes ❒ No
ADD / ADHD	❒ Yes ❒ No	Anxiety	❒ Yes ❒ No
Panic Attacks	❒ Yes ❒ No	Schizophrenia	❒ Yes ❒ No
Personality Disorders	❒ Yes ❒ No	Other:	_____

Have you ever had any of the follow STDs:

Chlamydia	❒ Yes ❒ No	Gonorrhea	❒ Yes ❒ No
Herpes	❒ Yes ❒ No	Venereal Warts	❒ Yes ❒ No
Syphilis	❒ Yes ❒ No	Trichomonas	❒ Yes ❒ No
HIV (AIDS)	❒ Yes ❒ No	HPV	❒ Yes ❒ No

Other: _____

Family Medical History:

(Please list relative, specify if maternal or paternal)

High Blood Pressure	❒ Yes ❒ No	_____
High Cholesterol	❒ Yes ❒ No	_____
Heart Disease	❒ Yes ❒ No	_____
Colon Cancer	❒ Yes ❒ No	_____
Thyroid Disease	❒ Yes ❒ No	_____
Diabetes	❒ Yes ❒ No	_____
Breast cancer	❒ Yes ❒ No	_____
Ovarian cancer	❒ Yes ❒ No	_____

Other: _____

Please answer the following if you are here for OR are interested in an aesthetic visit / consultation:

Do you form thick or raised scars from cuts or burns? ❒ Yes ❒ No

After injury to the skin, (cuts / burns) do you have:

Darkening of the skin in that area ❒ Yes ❒ No Lightening of the skin in that area ❒ Yes ❒ No

Hair removal- plucking, waxing, electrolysis in the last 4 weeks? ❒ Yes ❒ No

Tanning bed/sun exposure in the last 4 weeks? ❒ Yes ❒ No Tanning products spray on in the last 2 weeks? ❒ Yes ❒ No

Do you have a tan now in the area to be treated? ❒ Yes ❒ No

Have you used Accutane in the last 6 months? ❒ Yes ❒ No Do you have skin allergies or sensitivities? ❒ Yes ❒ No

Have you had previous laser or skin treatments? ❒ Yes ❒ No

Please check all medical conditions past or present

Cold sores ❒ Yes ❒ No Easy bruising or bleeding ❒ Yes ❒ No Poor healing ❒ Yes ❒ No

Moles that recently have changed, itch or bleed ❒ Yes ❒ No Skin cancer or precancerous lesions ❒ Yes ❒ No