Pearl W. Yee, M.D. Inc.
Obstetrics • Gynecology • Medical Aesthetics • Menopause • Prevention of Hereditary Cancer
Minimally Invasive and Robotic Gynecological Surgery

Initial Intake Form

Date:_______/ _______/_______ Age:___________________________

Name:____ Birth Date:_______/_______/______

Address:____
Street City State Zip Code

_____________________________ _____________________________ _____________________________
Home Phone # Cell Phone# Work Phone#

E-mail address:____ Preferred Language(s) ___________________

Primary Care Physician:___________________________________ Referred by:___________________________

Is there anything you want to talk to your physician about?

____

____

Medications: (include over the counter)

Drug Names	Dosage

Allergies/Sensitivity: drugs, latex, environment, food

Gynecological History

Have you ever been treated for: ☐ Herpes ☐ Chlamydia ☐ Gonorrhea
☐ Genital Warts ☐ Bacterial Vaginitis ☐ Trichomonas ☐ Syphilis

Have you had a Pap smear in the last 7 years? ☐ No ☐ Yes
Have you ever had an abnormal Pap smear? ☐ No ☐ Yes When?_______________
What Abnormality?____

Are you currently sexually active? ☐ No ☐ Yes ☐ Never
Did you begin sexual activity before 16 yo? ☐ No ☐ Yes If yes, Age started: ____
Have you had > 5 sexual partners in your lifetime? ☐ No ☐ Yes
Sexual Orientation: Heterosexual / Lesbian / Bi-Sexual / ________________________________

Menstrual History:
When was the first day of your last menstrual period or menopause? __________________
How long do your periods last? ________ days
How many days apart are your menstrual cycles starting from the first day of one cycle to the first day of your next cycle?____
What age did you start having menses?________________________

Name:______________________________ DOB:______________________________

Gynecological History (Cont.)

Are you currently using birth control? ☐ No ☐ Yes ☐ Trying to get pregnant
Are you taking birth control pills or any hormones? Yes / No
Current birth control method used: ______________________________
Are you satisfied with it? ☐ No ☐ Yes

Past birth control methods:

☐ Condoms	☐ Birth control pills	☐ Withdrawal	☐ Tubal Ligation
☐ Diaphragm	☐ Patch	☐ Rhythm	☐ Vasectomy
☐ Vaginal Film	☐ Vaginal Ring	☐ IUD	☐ Essure

Have you ever tested positive for HIV? ☐ No ☐ Yes
Did your mother take the drug DES when she was pregnant with you? ☐ No ☐ Yes

Pregnancy History

	Number		Number		Number
Total time pregnant		Full term deliveries		Vaginal deliveries	
Miscarriages		Deliveries before 37 wks		Cesarean sections	
Abortions		Living children		Forceps or vacuums	
Describe any special pregnancy problems:					

Personal Medical History

Major Illnesses	**Yes**		**Yes**		**Yes**
Diabetes		Heart Disease/MVP		Anxiety	
High Blood Pressure		High cholesterol		Depression	
GI disease		Hepatitis		Seizures	
GI Reflux disease		Liver problem		Asthma	
Fibroids		Kidney infections/stones		Lung disease	
Endometriosis		Arthritis		Tuberculosis	
Osteopenia		Joint Pain		Thyroid disease	
Osteoporosis		Fracture		Clotting problem	
Cancer (Breast/Ovary/Uterus/Colon/Etc.):					
Other:					

Surgical History

Surgery	Year	Surgery	Year

Name:________________________________ DOB:________________________________

Family History

Major Illnesses	**Yes**		**Yes**		**Yes**
Diabetes		Heart Disease		Anxiety	
High Blood Pressure		High cholesterol		Depression	
GI disease		Hepatitis		Seizures	
GI Reflux disease		Liver problem		Asthma	
Fibroids		Kidney infections/stones		Lung disease	
Endometriosis		Arthritis		Tuberculosis	
Osteopenia		Joint Pain		Thyroid disease	
Osteoporosis		Fracture		Clotting problem	
Family History of Cancer (Breast/Ovary/Uterus/Colon/Etc.):					
Other:					

Social History

Personal Profile

Birth Place:___________________________ Ethnicity:____________________ Religion:_________________

Marital status: ☐ Married ☐ Divorced ☐ Single ☐ Widowed
☐ Significantly Involved ☐ Domestic Partner

School Completed: ☐ High School ☐ College ☐ Graduate Degree ☐ Other

Exercise: ☐ Yes ☐ No How often____
Type:____
Special Diet ☐ Yes ☐ No Type____

Hobbies, Interests, Goals:____
____

Habits

Smoking: ☐ Yes ☐ No Packs/day_________ Years____________ Quit when:_________
Alcohol: ☐ Yes ☐ No Drinks/day________ Drinks/week______ Quit when:_________
Drug Use ☐ Yes ☐ No Type______________ Years____________ Quit when:_________
Caffeine ☐ Yes ☐ No Cups per day______________ Cups per week_____________

Do you use seatbelts? ☐ Yes ☐ No Do you use sunscreen? ☐ Yes ☐ No
Do you own guns in your home? ☐ Yes ☐ No If yes, is it in a secure location? ☐ Yes ☐ No

Personal Safety

☐ Yes ☐ No Has anyone close to you ever threatened to hurt you?
☐ Yes ☐ No Has anyone ever hit, kicked, choked or hurt you physically?
☐ Yes ☐ No Has anyone, including you partner, every forced you to have sex?
☐ Yes ☐ No Are you ever afraid of your partner?

Name:________________________________ DOB:_________________________________

Review of Systems

Please check if you have any of the following symptoms:

1. Constitutional		**Notes**
Fever	☐	
Chills	☐	
Fatigue	☐	
Weight loss	☐	
Weight gain	☐	
2. Eyes		
Change in vision	☐	
Double vision	☐	
3. ENT/Mouth		
Ear aches	☐	
Ringing in the ears	☐	
Sinus problems	☐	
Sore throat	☐	
Mouth sores	☐	
Dry Mouth	☐	
4. Cardiovascular		
Chest pain	☐	
Difficulty breathing on exertion	☐	
Swelling of legs	☐	
Palpitations	☐	
Heart Murmurs	☐	
5. Respiratory		
Wheezing	☐	
Spitting up blood	☐	
Shortness of breath	☐	
Cough	☐	
6. Gastrointestinal		
Diarrhea	☐	
Constipation	☐	
Nausea/vomiting	☐	
Bloody stool	☐	
Abdominal pain	☐	
Indigestion	☐	
Bloating	☐	
Liver problem/Hepatitis	☐	
7. Genitourinary		
Blood in urine	☐	
Pain with urination	☐	
Urgency	☐	
Urinary Frequency	☐	
Urinary Incontinence	☐	

7. Genitourinary (cont.)		**Notes**
Abnormal bleeding	☐	
Vaginal discharge/odor	☐	
Vaginal itching/burning	☐	
Pelvic pain	☐	
Menstrual cramps	☐	
Painful intercourse	☐	
Genital lump	☐	
Fertility concerns	☐	
Menopausal concerns	☐	
8. Musculoskeletal		
Muscle weakness	☐	
Joint stiffness	☐	
Joint pain	☐	
Joint swelling	☐	
9. Skin/Breast		
Breast pain	☐	
Nipple discharge	☐	
Breast lumps	☐	
Rash	☐	
Ulcers	☐	
10. Psychiatric		
Depression	☐	
Mood swings	☐	
Anxiety	☐	
Suicidal thoughts	☐	
Homicidal thoughts	☐	
11. Endocrine		
Abnormal thirst	☐	
Hot flashes	☐	
Tremors	☐	
Cold/heat intolerance	☐	
12. Hematologic		
Frequent bruising	☐	
Cuts do not stop bleeding	☐	
Enlarged lymph nodes	☐	
13. Had blood transfusion?	☐	
14. Any antibiotics needed before dental work?	☐	
15. How tall are you?	☐	

Please bring the above to the attention of your Primary Care Physician if not addressed today.