LUMINA
NANCY A. CARLSON, M.D.

PATIENT INTAKE HISTORY

PATIENT NAME _____ AGE _____ DATE _____

GYNECOLOGIC HISTORY

LAST MENSTRUAL PERIOD (FIRST DAY) _____

AGE PERIODS STARTED _____

NUMBER OF DAYS OF BLEEDING _____

NUMBER OF DAYS BETWEEN BLEEDING _____

ANY RECENT CHANGES IN PERIODS: YES _____ NO _____ EXPLAIN:
_____

PRESENT FORM OF BIRTH CONTROL: NONE _____ IUD _____ CONDOMS _____ TUBAL _____ VASECTOMY _____ PILLS _____

HAVE YOU EVER USED AN IUD? YES _____ NO _____ DATES _____ TYPE _____

LAST PAP (DATE AND RESULT)
_____

HISTORY OF ABNORMAL PAP? YES _____ NO _____ EXPLAIN:
_____

HISTORY OF GYNECOLOGICAL SURGERY? YES _____ NO _____ EXPLAIN:
_____

HISTORY OF POST MENOPAUSAL HORMONE USE: CURRENT _____ PAST _____ NEVER _____ TOTAL YEARS _____

HISTORY OF: HERPES _____ HPV _____ CHLAMYDIA _____ GONORRHEA _____

HISTORY OF INFERTILITY? YES _____ NO _____ IVF _____ CLOMID _____ IUI _____

SCREENING TESTS	**DATE** (MOST RECENT)
CHOLESTEROL	_____
COLONOSCOPY	_____
DXA BONE DENSITY	_____
MAMMOGRAM	_____
PAP SMEAR	_____

OBSTETRICAL HISTORY

TOTAL #of PREGNANCIES _____ LIVING CHILDREN _____

TERM BIRTHS _____ PRETERM (<37weeks) _____ ABORTIONS _____ MISCARRIAGES _____

	BIRTH DATE	WEIGHT	SEX	WEEKS PREGNANT	DELIVERY/COMPLICATION
1					
2					
3					
4					

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MEDICATIONS (INCLUDE VITAMINS AND SUPPLEMENTS)

1. 4.
2. 5.
3. 6.

ALLERGIES & Reactions

MEDICATIONS _____

ENVIRONMENTAL _____

LATEX YES _____ NO _____

TOBACCO

CURRENT YES _____ NO _____ PACKS PER DAY _____ NUMBER OF YEARS _____

PAST YES _____ NO _____ PACKS PER DAY _____ NUMBER OF YEARS _____

NEVER _____

ALCOHOL

DRINKS PER DAY _____ DRINKS PER WEEK _____

HOW MUCH CALCIUM DO YOU TAKE EVERY DAY AS A SUPPLEMENT? _____

HOW MUCH VITAMIN D DO YOU TAKE? _____

DO YOU HAVE AN ADVANCED DIRECTIVE OR LIVING WILL? YES _____ NO _____

PERSONAL PROFILE

MARITAL STATUS: Single / Married / Civil Union / Divorced / Widowed / Live with Partner

EDUCATION: High School / GED / College / Graduate Degree

TRAVEL OUTSIDE THE US: Never / Rarely / Occasionally / Frequently

PAST MEDICAL HISTORY

ILLNESS	YES	NO	DATES, TREATMENT, ACTIVE, RESOLVED
MIGRAINES			
SEIZURES			
GLAUCOMA			
THYROID DISEASE			
BREAST CANCER			
CANCER			
ASTHMA			
LUNG DISEASE			
HEART DISEASE			
HIGH CHOLESTEROL			
HIGH BLOOD PRESSURE			
LIVER DISEASE			
GALL BLADDER DISEASE			
DIABETES			
ULCERS			
BOWEL DISEASE			

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KIDNEY DISEASE			
INCONTINENCE			
BLADDER INFECTIONS			
HIV/AIDS			
ANEMIA			
EATING DISORDER			
MENTAL ILLNESS			
TRANSFUSION			
BROKEN BONES			
OTHER			

OPERATIONS

OPERATION	DATE	COMPLICATIONS/NOTES

FAMILY HISTORY

ILLNESS	**YES**	**NO**	**FAMILY MEMBER / AGE OF DIAGNOSIS**
OVARIAN CANCER			
UTERINE CANCER			
COLON CANCER			
BREAST CANCER			
OTHER CANCER (explain)			
OSTEOPOROSIS			
DIABETES			
BLOOD CLOTS			
HIGH BLOOD PRESSURE			
HIGH CHOLESTEROL			
STROKE			
HEART DISEASE			
BIRTH DEFECTS			
DEPRESSION			
MENTAL ILLNESS/ALZHEIMER'S			
ALCOHOLISM			
DRUG ABUSE			
OTHER			

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IMMUNIZATIONS

VACCINATION	DATE
TETANUS	
HEPATITIS B	
VARICELLA	
INFLUENZA	
GARDASIL	

_____ _____

PATIENT SIGNATURE DATE