Place Patient Label HERE

IGO

HEALTH HISTORY and CURRENT ASSESSMENT

IGO Medical Group, AMC
9339 Genesee Ave, Suites 200 & 220
San Diego, CA 92121
Phone: 858-455-7520
Fax: 858-554-1312

Name _____ Age _____ Date of Birth _____

Marital Status _____ Spouse's Name _____ Name of PCP _____

First Day of Last Menstrual Period ____/____/____ Method of Contraception _____

Reason for Today's Visit: ☐ **Annual Exam** ☐ **Concerns** _____

Current Medications (prescribed or over the counter) / Supplements / Herbs:

Medication / Dose	Medication / Dose	Medication / Dose

List Allergies to Medications (including reaction):

Medication / Reaction	Medication / Reaction

Past Medical and Family History: (For yourself, provide details and dates. For family members, please check if yes.)

Disease / condition	**YOURSELF**	Mother	Father	Sibling	Child	Other
Diabetes						
Hypertension						
Heart Disease						
Cancer: Breast						
Cancer: Ovarian						
Cancer: Uterine						
Cancer: Colon						
Cancer: Other (Type)						
Birth Defect						
Alcohol / Drug Abuse						
Bowel Problems						
Hepatitis						
Neurological Disease						
Osteoporosis						
Depression / Anxiety						
Lung Disease						
Stroke						
Thyroid Disease						
High Cholesterol						
Eating Disorder						
Other Health Issues						

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List any Surgeries or Hospitalizations you have had:

Description	Date

Substance and Sexuality:

Tobacco use?	Yes ☐	No ☐	Type _____
Past tobacco use?	Yes ☐	No ☐	# cigarettes per day _____ Age began _____ Age quit _____
Drug use?	Yes ☐	No ☐	Type _____
Alcohol use?	Yes ☐	No ☐	Amount per day / week _____
Are you sexually active?	Yes ☐	No ☐	With: Men ☐ Women ☐ Both ☐
Method of Contraception _____			

Social:

Single ☐ Partnered ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐			
Do you work outside the home?	Yes ☐	No ☐	If yes, what is our occupation? _____
Do you exercise?	Yes ☐	No ☐	Type / frequency _____

Pregnancies (list in order including miscarriages, ectopic and abortions):

Date	Sex	Weight	Complications (C-sections, etc)

Gynecologic History:

Age at first period _____				Do you plan to become pregnant soon?	Yes ☐	No ☐
Post-menopausal?	Yes ☐	No ☐		New sexual partner in the last year?	Yes ☐	No ☐
How many days between periods (average)? _____			N/A ☐	Date of last Pap _____/_____/_____		
How long do periods last? _____			N/A ☐	History of abnormal Pap smears?	Yes ☐	No ☐
Bleeding between periods?	Yes ☐	No ☐	N/A ☐	History of sexually transmitted infections?	Yes ☐	No ☐
Bleeding after menopause?	Yes ☐	No ☐	N/A ☐	If yes, type _____		
Are periods too heavy/too painful?	Yes ☐	No ☐	N/A ☐	History of sexual abuse?	Yes ☐	No ☐
Do you have sexual concerns?	Yes ☐	No ☐		Current sexual or physicial abuse?	Yes ☐	No ☐
Is intercourse painful?	Yes ☐	No ☐		Do you perform self breast exams?	Yes ☐	No ☐

Other Past GYN Issues:

1.
2.
3.

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The Patient Health Questionnaire-2 (PHQ-2):

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things				
Feeling down, depressed or hopeless				

Review of Systems (Please circle any of the following problems that you have experienced over the past year):

Constitutional:	Unusual fatigue	Weight loss	Loss of appetite
Eyes:	Double vision	Blurred vision	Glasses / contacts
ENT:	Deafness	Hoarseness	Ringing in ears
Cardiac:	Chest pains	Irregular beats	Palpitations
Pulmonary:	Shortness of breath	Chronic coughs	Wheezing
Gastrointestinal:	Blood in stool	Chronic diarrhea	Black stools
Musculoskeletal:	Pain in joints	Lower back pain	Muscle weakness
Skin:	Bruising	Hair loss	Unexplained rash
Neurologic:	Seizures	Frequent headaches	Numbness
Psychiatric:	Depressed	Difficulty sleeping	Memory loss
Endocrine:	Hot flashes	Dry skin	Sensitive to heat / cold
Blood disease:	Anemia	Bleeding problems	Enlarged lymph gland
Allergy:	Sinus problems	Allergic reaction	Conjunctivitis
OB/GYN:	Abnormal vaginal bleeding	Vaginal discharge	Pelvic pain

Assessment completed by _____ **Date** _____