Place Patient Label HERE

IGO

HEALTH HISTORY and CURRENT ASSESSMENT

Two Pages (Front and Back)

IGO Medical Group, AMC
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San Diego, CA 92121
Phone: 858-455-7520
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Name _____ Age _____ Date of Birth _____

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

Name of PCP _____ Referred to IGO by: _____

Reason for Today's Visit:

Annual Exam? Yes ☐ No ☐ Other 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

Medical Problems (past and current):

Description	Age at Diagnosis

List any Surgeries or Hospitalizations you have had:

Description	Date

Family History:

Disease / condition	Family Member	Age at Diagnosis	Disease / condition	Family Member	Age at Diagnosis
Cancer: Breast			Diabetes		
Cancer: Ovarian			High Cholesterol		
Cancer: Uterine			Birth Defect		
Cancer: Colon			Osteoporosis		
Cancer: Other (Type)			Other Health Issues		

Social:

Single ☐ Partnered ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Spouse/Partner Name _____

Do you work outside the home? Yes ☐ No ☐ If yes, what is our occupation? _____

Do you exercise? Yes ☐ No ☐ Type / frequency _____

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 ☐

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

Date	Sex	Weight	Complications (C-sections, etc)

Gynecologic History:

Age at first period _____			
How many days between periods (average)? _____			N/A ☐
How long do periods last? _____			N/A ☐
Bleeding between periods?	Yes ☐	No ☐	N/A ☐
Are periods too heavy/too painful?	Yes ☐	No ☐	N/A ☐
Do you have sexual concerns?	Yes ☐	No ☐	
New sexual partner in the last year?	Yes ☐	No ☐	

History of abnormal Pap smears?	Yes ☐	No ☐
History of sexually transmitted infections?	Yes ☐	No ☐
If yes, type _____		
History of sexual abuse?	Yes ☐	No ☐
Current sexual or physicial abuse?	Yes ☐	No ☐
Do you perform self breast exams?	Yes ☐	No ☐

Other Past GYN Issues:

1.
2.
3.

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** _____