

Place Patient Label HERE



IGO Medical Group, AMC
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**NEW PATIENT HEALTH HISTORY
 and CURRENT ASSESSMENT**
Two Pages (Front and Back)

Name _____ Age _____ Date of Birth _____

First Day of Last Menstrual Period ___/___/___ Date of Last Colonoscopy _____ N/A
 Date of Last Bone Densitometry _____ N/A

Method of Contraception (please circle):
 Oral Contraceptive Pills IUD Implant NuvaRing Condoms Tubal Ligation Hysterectomy Vasectomy Menopause Nothing

Name of PCP _____ Referred to IGO by: _____

Reason for Today's Visit:

Annual Exam? Yes <input type="checkbox"/> No <input type="checkbox"/> Other GYN 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 (document whether the family member is on your Maternal or Paternal side):

Disease / condition	Family Member	Maternal / Paternal	Age at Diagnosis	Disease / condition	Family Member	Maternal / Paternal	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 <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Spouse/Partner Name _____
Do you work outside the home? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, what is your occupation? _____
Do you exercise? Yes <input type="checkbox"/> No <input type="checkbox"/> Type / frequency _____

Substance and Sexuality:

Tobacco use?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Type _____
Past tobacco use?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	# cigarettes per day _____ Age began _____ Age quit _____
Drug use?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Type _____
Alcohol use?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Amount per day / week _____
Do you engage in sex?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	<input type="checkbox"/> Steady Partner <input type="checkbox"/> Different Partners <input type="checkbox"/> Men <input type="checkbox"/> Women <input type="checkbox"/> Both

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

Date	Sex	Weight	Complications (C-sections, etc)

Gynecologic History:

Age at first period _____	History of abnormal Pap smears? Yes <input type="checkbox"/> No <input type="checkbox"/>
How many days between periods (average)? _____ N/A <input type="checkbox"/>	History of sexually transmitted infections? Yes <input type="checkbox"/> No <input type="checkbox"/>
How long do periods last? _____ N/A <input type="checkbox"/>	If yes, type _____
Bleeding between periods? Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	History of sexual abuse? Yes <input type="checkbox"/> No <input type="checkbox"/>
Are periods too heavy/too painful? Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	Current sexual or physical abuse? Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you have sexual concerns? Yes <input type="checkbox"/> No <input type="checkbox"/>	Do you perform self breast exams? Yes <input type="checkbox"/> No <input type="checkbox"/>
New sexual partner in the last year? Yes <input type="checkbox"/> No <input type="checkbox"/>	

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

Form completed by _____ Date _____