Place Patient Label HERE

PATIENT HISTORY UPDATE

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 ____________________

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

Name of PCP ______________________________ Date of Last Colonoscopy _________________ ☐ N/A
Date of Last Bone Densitometry _________________ ☐ N/A

NEW GYN Concerns Since Last Visit:

NEW Medical Problems or NEW Surgeries Since Last Visit:

Description	Age at Diagnosis

NEW Family History or NEW Family Conditions Since Last Visit:

Description	Date

Social History:

Tobacco use?	Yes ☐	No ☐	Type ____________________
Drug use?	Yes ☐	No ☐	Type ____________________
Alcohol use?	Yes ☐	No ☐	Amount per day / week ____________________
Do you engage in sex?	Yes ☐	No ☐	☐ Steady Partner ☐ Different Partners ☐ Men ☐ Women ☐ Both
Do you exercise regularly?	Yes ☐	No ☐	Comments ____________________

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 that have been a SIGNIFICANT PROBLEM for you 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** ____________________