Place Patient Label HERE

NEW PATIENT HEALTH HISTORY and CURRENT ASSESSMENT

Two Pages (Front and Back)

IGO Medical Group, AMC
9339 Genesee Ave, Suites 200 & 220
San Diego, CA 92121
Phone: 858-455-7520
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Name ______________________ Age ________ Date of Birth ______________

First Day of Last Menstrual Period ____/____/____

Date of Last Colonoscopy ______________ ☐ N/A
Date of Last Bone Densitometry ______________ ☐ N/A
Date of Last Mammogram ______________ ☐ 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 ☐ No ☐ 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				Hypertension			
Cancer: Colon				Osteoporosis			
Cancer: Other (Type)				Other Health Issues			

Please turn the page over and complete the back →

Social:

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

Do you work outside the home? Yes ☐ No ☐ If yes, what is your 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 ____________________

Do you engage in sex? Yes ☐ No ☐ ☐ Steady Partner ☐ Different Partners ☐ 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
Cardiac:	Chest pains	Irregular beats	Palpitations
Pulmonary:	Shortness of breath	Chronic coughs	Wheezing
Gastrointestinal:	Blood in stool	Chronic diarrhea	Black stools
Neurologic:	Seizures	Frequent headaches	Numbness
Endocrine:	Hot flashes	Dry skin	Sensitive to heat / cold
Blood disease:	Anemia	Bleeding problems	Enlarged lymph gland
OB/GYN:	Abnormal vaginal bleeding	Vaginal discharge	Pelvic pain

Form completed by ____________________ **Date** ____________