Place Patient Label HERE

IGO

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 _____

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: _____

NEW GYN Concerns Since Last Visit:

Gynecologic History:

How many days between periods (average)? _____			N/A ☐	History of abnormal Pap smears?	Yes ☐	No ☐
How long do periods last? _____			N/A ☐	History of sexually transmitted infections?	Yes ☐	No ☐
Bleeding between periods?	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 ☐
New sexual partner in the last year?	Yes ☐	No ☐		Do you perform self breast exams?	Yes ☐	No ☐

NEW Medical Problems or Surgeries Since Last Visit:	**NEW Family History or Family Conditions Since Last Visit:**

Social, Substance and Sexuality:

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 _____
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 week _____
Do you engage in sex?	Yes ☐	No ☐	☐Steady Partner ☐Different Partners with: ☐Men ☐Women ☐Both

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
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** _____