Place Patient Label HERE

IGO

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
Date of last Pap _____ ☐ 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, Procedures or Hospitalizations you have had (including cosmetic):

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 _____

Employment? 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 week _____

Do you engage in sex? Yes ☐ No ☐ ☐Steady Partner ☐Different Partners 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 _____

Do you have a monthly cycle? Yes ☐ No ☐

Days between start of one period and start of the next _____

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 perform self breast exams? 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, emotional or physicial abuse? Yes ☐ No ☐

Do you have sexual concerns? Yes ☐ No ☐

New sexual partner in the last year? Yes ☐ No ☐

Other Past GYN Issues:

1.

2.

4.

5.

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 check 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** _____