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
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: _____

NEW GYN Concerns Since Last Visit:

NEW Medical Problems, Procedures or Surgeries (including cosmetic) Since Last Visit:

NEW Family History or Family Conditions Since Last Visit:

Gynecologic History:

Do you have a monthly cycle?	Yes ☐	No ☐	History of abnormal Pap smears?	Yes ☐	No ☐
# Days between start of one period and start of the next _____			History of sexually transmitted infections?	Yes ☐	No ☐
How long do periods last? _____ N/A ☐			If yes, type _____		
Bleeding between periods?	Yes ☐	No ☐ N/A ☐	History of sexual abuse?	Yes ☐	No ☐
Are periods too heavy/too painful?	Yes ☐	No ☐ N/A ☐	Current sexual, emotional or physicial abuse?	Yes ☐	No ☐
Do you have sexual concerns?	Yes ☐	No ☐	Do you perform self breast exams?	Yes ☐	No ☐
New sexual partner in the last year?	Yes ☐	No ☐			

Social, Substance and Sexuality:

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 _____
Tobacco use?	Yes ☐	No ☐	Type _____
Past tobacco use?	Yes ☐	No ☐	# cigarettes per day _____ Age began _____ Age quit _____
Alcohol use?	Yes ☐	No ☐	☐Monthly or less ☐2-3 times/month ☐2-3 times/week ☐>4 times/week
Drug use?	Yes ☐	No ☐	Type _____
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 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** _____