

Place Patient Label HERE



IGO Medical Group, AMC  
 9339 Genesee Ave, Suites 200 & 220  
 San Diego, CA 92121  
 Phone: 858-455-7520  
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**PATIENT HISTORY  
 UPDATE**

Name \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

First Day of Last Menstrual Period \_\_\_\_/\_\_\_\_/\_\_\_\_ Date of Last Colonoscopy \_\_\_\_\_  N/A  
 OR your age at Menopause \_\_\_\_\_ 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:**

History of:	Do you have a monthly cycle? Yes <input type="checkbox"/> No <input type="checkbox"/>
Abnormal Pap smears? Yes <input type="checkbox"/> No <input type="checkbox"/>	# Days between start of one period and start of the next _____ N/A <input type="checkbox"/>
Sexually transmitted infections? Yes <input type="checkbox"/> No <input type="checkbox"/>	How long do your periods last? _____ N/A <input type="checkbox"/>
If yes, type of STD: _____	Bleeding between periods? Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>
	Are periods too heavy/too painful? Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>

**Social, Substance and Sexuality:**

Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/>	Spouse/Partner Name _____
Employment? Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, what is your occupation? _____
Do you exercise? Yes <input type="checkbox"/> No <input type="checkbox"/>	Type / frequency _____
Tobacco use? Yes <input type="checkbox"/> No <input type="checkbox"/>	Type _____
Past tobacco use? Yes <input type="checkbox"/> No <input type="checkbox"/>	# cigarettes per day _____ Age began _____ Age quit _____
Alcohol use? Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/> Monthly or less <input type="checkbox"/> 2-3 times/month <input type="checkbox"/> 2-3 times/week <input type="checkbox"/> >4 times/week
Drug use? Yes <input type="checkbox"/> No <input type="checkbox"/>	Type _____
Do you engage in sex? Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/> Steady Partner <input type="checkbox"/> Different Partners with: <input type="checkbox"/> Men <input type="checkbox"/> Women <input type="checkbox"/> Both
Do you have sexual concerns? Yes <input type="checkbox"/> No <input type="checkbox"/>	Current sexual, emotional or physical abuse? Yes <input type="checkbox"/> No <input type="checkbox"/>
New sexual partner in the last year? Yes <input type="checkbox"/> No <input type="checkbox"/>	History of sexual abuse? Yes <input type="checkbox"/> No <input type="checkbox"/>

**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				

Form completed by \_\_\_\_\_ Date \_\_\_\_\_