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	Reason

List Allergies to Medications (including reaction):

Medication	Reaction

Medical Problems (past and current):

Description	Age at Diagnosis
History of abnormal Pap? ☐ No ☐ Yes	
History of sexually transmissed infections? ☐ No ☐ Yes	
Other:	

List any Surgeries, Procedures or Hospitalizations you have had (including cosmetic):

Description	Date

Please turn the page over and complete the back →

Pregnancies (list in order including miscarriages, ectopic and abortions):

Date	Sex	Weight	Complications (C-sections, etc)

Menstrual Cycles:

Do you have a monthly cycle? Yes ☐ No ☐

Days between start of one period and start of the next _____ N/A ☐

How long do your periods last? _____ N/A ☐

Bleeding between periods? Yes ☐ No ☐ N/A ☐

Are periods too heavy/too painful? Yes ☐ No ☐ N/A ☐

If you do not have monthly cycles:

Are you Post-Menopausal? Yes ☐ No ☐

Age at Menopause _____

Any other explanation for no periods:

_____

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

Do you have sexual concerns? Yes ☐ No ☐ Current sexual, emotional or physical abuse? Yes ☐ No ☐

New sexual partner in the last year? Yes ☐ No ☐ History of sexual abuse? Yes ☐ No ☐

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				

Family History (document whether the family member is on your Maternal or Paternal side):

Disease / Condition	Family Member	Maternal / Paternal	Age at Diagnosis
Cancer: Breast			
Cancer: Ovarian			
Cancer: Uterine			
Cancer: Colon			
Cancer: Other (Type)			
Diabetes			
High Cholesterol			
Hypertension			
Osteoporosis			
Other Health Issues			

Form completed by _____ **Date** _____