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 ____/____/____
OR your age at Menopause _____

Date of Last Colon Cancer Screen _____ ☐ 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:

History of:
Abnormal Pap smears? Yes ☐ No ☐
Sexually transmitted infections? Yes ☐ No ☐
If yes, type of STD:
_____
_____

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

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				

Form completed by _____ **Date** _____