Place Patient Label HERE

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 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: ______________________________

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 GYN problems:	

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? Yes ☐ No ☐ N/A ☐
Are periods 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** ____________________