Name____________________

DOB__________

place patient label here

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

Primary Care Physician ________________________________

Method of Contraception (please circle):

Oral Contraceptive Pills IUD Implant NuvaRing Condoms
Tubal Ligation Hysterectomy Vasectomy Menopause Nothing

First Day of Last Menstrual Period ____/____/____
OR your age at Menopause ___________

Health Maintenance	None	Done at IGO	Done Elsewhere Date/Location
Last Pap smear			
Last Mammogram			
Last Bone Density			
Last Colon Cancer Screen			

History of:

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

How many days between your cycles? __________
Do you have any concerns about your monthly cycle?
____

NEW GYN Concerns Since Last Visit:

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

NEW Family History or Family Conditions Since Last Visit:

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 ____
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** __________________