New Life
OB/GYN ASSOCIATES

New Gynecology Patient Health Summary

Patient Name _____ Age _____ DOB _____

Phone _____ Today's Date _____

Reason for visit (state onset, duration, location, severity, associated symptoms):

_____

_____

Personal Profile

Referred by: _____ Current or Most Recent Job: _____

Marital Status: ☐Married ☐Living with Partner ☐ Single ☐ Widowed ☐Divorced

Sexual Orientation: ☐ Heterosexual ☐ Homosexual ☐ Bisexual

Menstrual History

Date of last Menstrual Period _____ ☐Definite ☐Approx (Month Known) ☐Unknown

Any recent changes or problems with your cycle? _____

What are you doing for birth control? _____

Have you ever had sex? ☐ Yes ☐ No Are you currently sexually active? ☐Yes ☐ No

Number of lifetime sexual partners? _____ Sexual partners are ☐ Men ☐ Women ☐ Both

Any history of STDs? ☐ Yes ☐ No If yes, please explain and give date: _____

Date of last PAP smear? _____ Have you ever had an abnormal PAP? ☐Yes ☐ No

Abnormality: _____ Treatment: _____

When was your last mammogram? _____ Where: _____

Have you ever had an abnormal mammogram? ☐Yes ☐No If yes, explain time and treatment? _____

When was your last colonoscopy? _____ Result: _____

When was your last bone scan? _____ Result: _____

Allergies

Drug	Reaction	Drug	Reaction

Check if you are allergic to: ☐ Shellfish ☐ Iodine ☐ Penicillin ☐ Latex

Medications

What medications are you currently taking (Including birth control pills and drugs you buy without a prescription)?

Drug	Dosage	Drug	Dosage	Drug	Dosage

Preferred Pharmacy and Location: _____ Phone: _____

Past Medical Illnesses (have you been treated for any of these?)

Yes	No	Illness	Yes	No	Illness
		Irregular Heart Beat			Kidney Stones
		Congestive Heart Failure			Chicken Pox (Have you had it)
		Heart Murmur			Sickle Cell Disease/Trait
		Rheumatic Fever			Arthritis
		Any other Heart Condition			Skin Disease, Type:
		Blood Clot in Leg, Lung or Varicose Veins			Stroke
		High Cholesterol			Epilepsy / Seizures
		High Blood Pressure			Migraine Headache
		Heart Murmur			Diabetes / High Blood Sugar
		Asthma			Thyroid Problems – too high or too low
		Emphysema / Chronic Bronchitis			Anemia / Low Blood
		Tuberculosis			Bleeding Problems Type:
		Gallstones			Blood Transfusion
		Liver Disease, Including Hepatitis			Cancer, Type:
		Ulcers in Bowels/Stomach			Anxiety or Depression
		Kidney Disease, Type:			Psychological Problems
		Genital Herpes, Genital Warts,			Sexually Transmitted Disease -If YES please circle: HIV, Chlamydia, Gonorrhea, Syphilis
		Infertility Treatments			
		Other:			Other:

Comments: _____

Other Specialty Doctors You See

Specialty	Name	City	Phone

Comments: _____

Past Medical Surgeries (have you been treated for any of these?)

Yes	No	Surgery	Date	Yes	No	Surgery	Date
		Appendectomy				Joint Replacement	
		Joint Scope Surgery				Back Disc Surgery	
		Biopsy of:				Abdominal Surgery	
		Open Heart Surgery				Tonsils Removed	
		Neck Artery Surgery				Wisdom Teeth Extraction	
		Eye Surgery R L				D&C	
		Gallbladder				Vaginal Surgery	
		Broken Bone Repair				Other:	

Comments: _____

Your Family History

(Disease affecting your parents, grandparents, brothers and sisters only. Please note the person)

Mother: ☐Living ☐Deceased Cause: _____ Age: _____ **Father:** ☐ Living ☐Deceased Cause: _____ Age: _____

Siblings: Number Living: _____ Number Deceased: _____ Cause(s)/Age(s): _____

Children: Number Living: _____ Number Deceased: _____ Cause(s)/Age(s): _____

Yes	No	Illness	Who	Yes	No	Illness	Who
		Heart Attack				Osteoporosis	
		High Blood Pressure				Blood Clots	
		High Cholesterol				Bleeding Problems	
		Asthma				Depression	
		Diabetes / High Blood Sugar				Stroke	
		Breast Cancer				Birth Defects	
		Ovarian Cancer				Infant Surgery	
		Colon Cancer				Infant Death	
		Kidney Disease				Alcoholism	
		Other: _____				Other: _____	

Comments: _____

Social History

Yes	No	Illness	Yes	No	Illness	Notes
		Tobacco Use			Folic Acid Intake	
		Alcohol Use			Calcium Intake	
		Illegal/Street Drug Use			Caffeine Intake	
		Misuse of Rx Drugs			Advance Directive (Living Will/Power of Attorney)	
		Domestic Violence/Child Abuse			Organ Donation	
		Sexual Abuse			Veteran Status	
		Health Hazards at Home/ Work			Safe Driving Practices	
		Regular Exercise			Dairy Products	

Comments: _____

Cancer Family History Questionaire

Patient Name _____ Age _____ DOB _____

Gender (circle) M / F Date ___/_____/___ Health Care Provider _____

Instructions: This is a screening tool for cancers that run in families. Please mark (Y) for those that apply to YOU and/or YOUR FAMIY. Next to each statement, please list the relationships to you and age of diagnosis for each cancer in your family. You and the following close blood relatives should be considered: You, Parents, Brothers, Sisters, Sons, Daughters, Grandparents, Grandchildren, Aunts, Uncles, Nephews, Nieces, Half-Siblings, First-Cousins, Great-Grandparents, Great Grandchildren

You and Your Family's Cancer History (Please be a thorough and accurate as possible)

	Cancer Type	You (age of diagnosis)	Parents/ Siblings/ Children	Age of diagnosis	Relatives on your Mother's Side	Age of diagnosis	Relatives on your Father's Side	Age of diagnosis
☐Y ☐N	Example: Breast Cancer	45			Aunt Cousin	45 61	Grandmother	53
☐Y ☐N	Breast Cancer							
☐Y ☐N	Ovarian Cancer							
☐Y ☐N	Uterine/Endometrial Cancer							
☐Y ☐N	Colon/Rectal Cancer							
☐Y ☐N	10 or more lifetime Colon Polyps (specify #)__							
☐Y ☐N	Other Cancers (specify type) _____							

Are you of Ashkenazi Jewish descent? ☐Y ☐N

Are you concerned about your personal and/or family history of cancer? ☐Y ☐N

Have you or anyone in your family had genetic testing for a hereditary cancer syndrome? ☐Y ☐N
(Please explain/include a copy of result if possible)

Hereditary Cancer Red Flags (To be completed with your healthcare provider - Check all that apply)

Your Personal History - Red Flags

Hereditary Breast and Ovarian Cancer Syndrome
- ☐ Breast cancer diagnosed at age 50 or younger
- ☐ Ovarian cancer at any age
- ☐ Two primary occurrences of breast cancer
- ☐ Male breast cancer
- ☐ Triple Negative Breast Cancer
- ☐ Pancreative cancer with a breast or ovarian cancer
- ☐ Ashkenazi Jewish ancestry with an HBOC-associated cancer*

Lynch Syndrome (see cancer list below)**
- ☐ Colorectal cancer under age 50
- ☐ Endometrial/uterine cancer under age 50
- ☐ MSI High histology*** before age 60
- ☐ Abnormal MSI/IHC tumor test result (colon/rectal/endometrial/uterine)
- ☐ Two or more Lynch syndrome cancers** at any age
- ☐ You and one or more relatives with a Lynch syndrome cancer**

Your Family History - Red Flags

Hereditary Breast and Ovarian Cancer Syndrome
- ☐ Close relative with breast cancer less than age 50
- ☐ Close relative with ovarian cancer at any age
- ☐ Two or more breast cancer occurrences in one relative or in two or more relatives on the same side of the family, one under age 50
- ☐ A male relative with breast cancer
- ☐ Combination of breast, ovarian and/or pancreative cancer on the same side of the family
- ☐ Three or more relatives with breast cancer at any age
  A previously identified BRCA1 or BRCA2 mutation in the family

Lynch Syndrome (see cancer list below)**
- ☐ Two or more relatives with Lynch syndrome cancers,** one before age 50
- ☐ Three or more relatives with Lynch syndrome cancers,** at any age
- ☐ A previously identified Lynch syndrome mutation in the family

*HBOC associated cancer includes: breast, ovarian and pancreatic cancer
**Lynch syndrome cancer includes: colon, endometrial/uterine, gastric/stomach, ovarian, ureter/rectal pelvis, biliary tract, small bowel, pancreas, brain and seboceous adenomas
***MSI High histology includes: Mucinous, signet ring, tumor infiltrating lymphocytes, crohn's-like mymphocytic reaction histology, or medullary growth pattern

Cancer Risk Assessment Review (To be completed after discussion with your healthcare provider)

Patient's Signature: _____ Date: _____

Health Care Provider's Signature: _____ Date: _____

For Office Use Only: Patient offered hereditary cancer genetic testing? ___ Y ___ N ___ Accepted ___ Declined
Follow-up appointment scheduled: ___ Y ___ N Date of next appointment: _____