Health ONE Premier Integrated OBGYN Physician Care℠

Date: _____

Name: _____ **If different, preferred name**: _____ **Age** _____

Preferred gender identity: Female☐ Male☐ Transgender Male/FTM☐ Transgender Female/MTF☐Gender Queer☐ Other☐

Sex assigned at birth: Female☐ Male☐ Other☐ Decline to answer☐

Would you like a chaperone in the room for your exams? Yes☐ No☐

MEDICATIONS:

Name	**Strength/Dose**	**How often do you take it?**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies and reaction: _____
Preferred pharmacy: _____ **Address or cross streets**: _____

MEDICAL HISTORY: ◯ No Medical Problems

◯ Allergies
◯ Anemia
◯ Anxiety
◯ Arthritis
◯ Asthma
◯ Blood transfusion (past)
◯ Blood clots (legs, lungs)
◯ Bowel Disease
◯ Cancer
◯ COPD
◯ Depression
◯ Diabetes
◯ Eating Disorder
◯ GERD/Acid Reflux
◯ Headaches/Migraines
◯ Heart Disease/Murmur
◯ Hepatitis
◯ High Cholesterol
◯ Hypertension
◯ Kidney Disease
◯ Osteoporosis
◯ Stroke
◯ Substance dependence
◯ Thyroid disease
◯ Other _____

GYNECOLOGICAL HISTORY:

First day of your last menstrual period (LMP): _____ How old were you when your period started? _____
Are your periods: Light☐Moderate☐Heavy☐ Are periods regular in their timing? Yes☐ No☐
How many days between your periods? _____ How many days of menstrual flow? _____
Do you have remarkable pain with your periods? Yes☐No☐ Do you have bleeding in-between periods? Yes☐No☐
If applicable, age of menopause/year of last period?_____ Taken hormone meds taken since menopause? Yes☐ No☐
Do you have any urinary or fecal incontinence? Yes☐No☐
Do you have any concerns or questions about your sexual health? Yes☐No☐
Are you sexually active now? Yes☐No☐
Sexual orientation: Straight☐ Gay☐ Lesbian☐ Bisexual☐
Current relationship status, circle all that apply: Single☐ Married☐ In a civil union☐Domestic partnership☐Multiple partners☐
Partnered, not cohabitating☐ Divorced☐ Widowed☐In a committed relationship☐ Other:☐_____
Name of partner(s):_____
Current form of birth control: _____ Are you happy with it? Yes☐No☐
Past methods of birth control (select all that apply): Rhythm/Natural Family Planning☐ Condoms☐ Withdrawal☐ Pill☐ Patch☐
Nuvaring☐ Depo-Provera Injections☐ Arm Implant☐ Hormone IUD☐ Copper IUD☐ Essure Sterilization☐ Tubal Ligation☐
Vasectomy☐Hysterectomy☐
Date of last Pap test: _____ Was it normal? Yes☐No☐ Ever had an abnormal Pap or Colposcopy? Yes☐No☐
Have you had any treatments to your cervix? No☐Cryosurgery☐Laser Surgery☐LEEP☐ Conization☐ Other☐_____
Have you ever had a sexually transmitted disease? No☐Chlamydia☐Gonorrhea☐ Herpes☐ Other ☐_____
Have you had the HPV vaccine (Gardasil) series? Yes☐No☐

FAMILY HISTORY: Check middle column if there is a family history of:

Illness	X	Family Member (example: Sister or Maternal Grandfather)
Diabetes		
High Blood Pressure		
Coronary Artery Disease/Heart attack		
High Cholesterol		
Breast Cancer		
Ovarian Cancer		
Lung Cancer		
Colon Cancer		
Pancreatic cancer		
Melanoma		
Substance dependence		
Depression/Anxiety		
Asthma		
Other		

SOCIAL HISTORY

Occupation: _____

Who do you live with at home? _____

Do you have history of substance dependence? Yes ☐ No ☐

How many alcoholic drinks do you have per week: _____

In the last year, have you felt guilty about your drinking, had more than 4 drinks in a day, or lost memory due to drinking ? Yes ☐ No ☐

Do you use recreational drugs (Marijuana, IV drugs, prescription drugs not prescribed to you)? Yes ☐ No ☐

If yes to the above, what do you use and how often? _____

Do you currently smoke? Yes ☐ No ☐

Are you ready to discuss quitting today? Yes ☐ No ☐

Have you EVER been a smoker? Yes ☐ No ☐

If yes: What age did you start smoking?: _____ #/day: _____ When did you quit? _____

PAST OPERATIONS/HOSPITALIZATIONS: ◯ No Surgical History

◯ Appendectomy ◯ Heart Surgery ◯ Colon Surgery ◯ Fracture/Trauma ◯ Plastic Surgery ◯ Brain/Spine

◯ Breast Surgery ◯ Hysterectomy ◯ Hernia Repair ◯ Tubal ligation ◯ Joint Replacement ◯ C-section

◯ Cholecystectomy (gallbladder) ◯ Other GYN surgery:_____

◯ Other surgery:_____

HEALTH CARE SCREENING QUESTIONS

Have you had a mammogram? Yes ☐ No ☐ Date of last mammo: _____

Have you ever had an abnormal mammogram, breast ultrasound or breast biopsy? Yes ☐ No ☐

Have you had a colonoscopy? Yes ☐ No ☐ Date of last colonoscopy: _____

Have you had a bone density test, for example DEXA scan? Yes ☐ No ☐

Do you adhere to any particular diet? Yes ☐ No ☐

Do you exercise regularly? Yes ☐ No ☐

If you exercise regularly, what type and how often do you exercise? _____

Has anyone close to you ever threatened to hurt you? Yes ☐ No ☐

Has anyone ever hit, kicked, choked or hurt you physically? Yes ☐ No ☐

Has anyone ever forced you into a sexual experience? Yes ☐ No ☐

Have you ever traded sexual acts for money, rent, food, services? Yes ☐ No ☐

Are you or have ever been afraid of your current partner? Yes ☐ No ☐

Do you wear a seatbelt? Yes ☐ No ☐

Do you wear sunscreen? Yes ☐ No ☐

Do you have any guns in your home? Yes ☐ No ☐

Are you planning a trip or have you been to a Zika endemic area in the last year ? Yes ☐ No ☐

Country you traveled to: ☐ Travel Date: ☐

Are you currently involved in any legal proceedings that may impact our care for you? Yes ☐ No ☐

PREGNANCY HISTORY: Please list all pregnancies in the table below, for pregnancies that you carried past 20 weeks *please list any complications* during the pregnancy, labor, delivery or post-partum period including preterm hospitalizations, depression/anxiety, gestational diabetes, high blood pressure/pre-eclampsia, weight gain greater than 35 pounds, stillbirth, 3rd or 4th degree delivery laceration, episiotomy, breech delivery, post-partum bleeding, uterine infection/chorioamnionitis, lactation concerns.

Year of pregnancy	Result of pregnancy ▫Delivery ▫Abortion ▫Miscarriage ▫Ectopic	Weeks at end of pregnancy	Mode of Delivery ▫Vaginal ▫ C-section ▫Forceps ▫Vacuum	If delivered, sex of baby and name	Infant weight	Name of partner in pregnancy	Complications

HAVE YOU EXPERIENCED ANY OF THE FOLLOWING SYMPTOMS IN THE LAST 2 WEEKS?

☐Yes☐No *Unintentional* weight loss/gain
☐Yes☐No Fever/Chills
☐Yes☐No Vision Changes
☐Yes☐No Headaches
☐Yes☐No Chest pain/shortness of breath *with exertion*
☐Yes☐No Skipped beat or heart palpitations
☐Yes☐No Breast lump or mass
☐Yes☐No Cough
☐Yes☐No Wheezing
☐Yes☐No Nipple discharge
☐Yes☐No Constipation
☐Yes☐No Diarrhea
☐Yes☐No Blood in stools

☐Yes☐No Nausea/vomiting
☐Yes☐No Abdominal pain
☐Yes☐No Frequent or painful urination
☐Yes☐No Loss of urine
☐Yes☐No Blood in the urine
☐Yes☐No New skin rashes
☐Yes☐No Mole changes
☐Yes☐No Extremity swelling
☐Yes☐No Joint Pain
☐Yes☐No Anxiety or Depression
☐Yes☐No Heat/cold intolerance
☐Yes☐No Numbness/Tingling
☐Yes☐No Weakness

Physician Signature _____ Date reviewed: _____