Date: ______________________

Health ONE Premier Integrated OBGYN Physician Care℠

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