Ivinson MEMORIAL HOSPITAL
MEDICAL GROUP

OB/GYN New Patient

Patient Information

Name (Last, First, Middle):____________________

Preferred Name:__________ Pronouns:__________ Date of Birth:__________ Age:__________

Address:____________________ City, State:__________

Phone:__________ Email:____________________

Preferred Contact Method: ☐Phone ☐Text ☐Email ☐Mail

Employer:____________________ Occupation:__________

Current Medications / Supplements		☐**See attached medication list.**
Medication / Supplement	Dose	Frequency

Allergies	☐**See attached allergy list.**
Medication or Substance	Reaction

Do you have any other allergies (latex, iodine, food, or environment)? ____________________

____

Surgical History	
Surgical Area or Procedure	Year completed, complications.

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Medical History: Do you have any health problems? (check all that apply)

☐Anxiety
☐Arthritis
☐Asthma
☐Bladder or Kidney Problems
☐History of Blood Transfusion
☐Breast Problems
☐Depression
☐Stomach or Bowel Problems
☐Heart Problems
☐High Blood Pressure
☐High Cholesterol
☐Lung Problems
☐Migraine Headaches
☐Neurologic Problems
☐Polycystic Ovarian Syndrome
☐Seasonal Allergies
☐Serious Injuries or Accidents
☐Thyroid Problems
☐Stomach Ulcers

Explain checked items and any other health problems:______________________________

____

____

Family History ☐Adopted ☐Family History Unknown

Is your mother alive? ☐Yes ☐No Age:________

If deceased, at what age and cause of death?______________________________

Mother's medical problems?______________________________

Is your father alive? ☐Yes ☐No Age:________

If deceased, at what age and cause of death?______________________________

Father's medical problems?______________________________

Family Medical Problems: Do any of your immediate family members have any of the following medical problems?

Medical Problem	**Family Member(s)** (brother, sister, mother, father, paternal/maternal grandparents)
Cancer (specify type)	
Blood Clot or Stroke	
Diabetes	
Heart Disease	
High Blood Pressure	
Thyroid Problems	
Other	

Are there any genetic or inherited health problems in your family? List problems and relationship:____________________

____

____

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Social History

Marital Status: ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed

Do you smoke cigarettes or e-cigarettes? .... ☐Current ☐Past ☐Never

How much?_________________ How many years?________ When did you quit?________________________

Do you use chewing tobacco, snuff, or other forms of tobacco? .... ☐Current ☐Past ☐Never

List what type:____

Do you use recreational drugs (marijuana, etc.)? .... ☐Current ☐Past ☐Never

List what type:____

Do you drink alcohol? .... ☐Current ☐Past ☐Never

How many glasses of wine, liquor, mixed drinks, or beer per week?____________

What is your highest level of education? ☐Grade School ☐High School ☐College ☐Other

Immunization History

Immunization	Date
Tdap (tetanus, diphtheria and pertussis)	
Tetanus	
Pneumonia Vaccine (PCV 23)	
Prevnar (PVC 13)	
Zostavax (shingles)	
Influenza (flu)	
Gardasil (HPV)	

Health Maintenance

Test / Procedure	Date
Bone Density (DEXA)	
Mammogram	
Pap Smear	
Wellness Labs	
Colonoscopy	

Pregnancy History

Total number of pregnancies (including miscarriages and terminations):________

Miscarriage (loss before 20 weeks):________ Pregnancy Terminations:________

Live Births:________

Full Term (37 weeks or more):________ Preterm (20-37 weeks):________

Vaginal Deliveries:________ Cesarean Deliveries:________

Living Children:________ Adopted Children:________ Deceased Children:________ Stillborn:_________

Do you have any complications with your pregnancies? ____

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Gynecologic History

When was the first day of your last menstrual period? ______/______/_______

If postmenopausal, at what age did your periods stop? ________

Skip the following questions if you are postmenopausal.

At what age was your first menstrual period? ________

How many days from the start of the period to the start of the next period? ________

How many days do they typically last? ________ Is your flow ☐Light ☐Moderate ☐Heavy

Do you bleed/spot between periods? ☐Yes ☐No Do you have painful periods? ☐Yes ☐No

When was your **last pap smear**? ______/______/______ Was it normal? ☐Yes ☐No

Have you ever had an **abnormal pap smear**? ☐Yes ☐No When? ______/______/______

Have you ever had a **procedure** for an **abnormal pap smear**? ☐Yes ☐No When? ______/______/______

What procedure? ____

Do you have **breast implants**? ☐Yes ☐No

When was your **last mammogram**? ____/______/______ Was it normal? ☐Yes ☐No

Have you ever had an **abnormal mammogram**? ☐Yes ☐No When? ______/______/______

Have you ever had a **breast biopsy**? ☐Yes ☐No When? ______/______/______

Are you sexually active? ☐Yes ☐No

What is your sexual orientation? _______________________________

How many sexual partners have you had in your lifetime?________

Have your sexual partners been ☐Male ☐Female ☐Both

Your current sexual partner(s) are ☐Male ☐Female ☐Both

Are you taking any hormones or using birth control? ____

Have you ever had a sexually transmitted infection? ☐Yes ☐No

If so, which? ____ When? ______/______/______

Have you ever been a victim of abuse? ☐Yes ☐No

Check all that apply: ☐Physical ☐Sexual ☐Verbal

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Please mark yes for any ***current symptoms*** you have.

Constitutional
Weight Gain ☐Yes ☐No
Weight Loss ☐Yes ☐No
Fatigue ☐Yes ☐No
Hot Flashes ☐Yes ☐No
Night Sweats ☐Yes ☐No

Eyes
Double Vision ☐Yes ☐No
Blurred Vision ☐Yes ☐No

HENT
Sore Throat ☐Yes ☐No
Headaches ☐Yes ☐No
Nasal Congestion ☐Yes ☐No
Ringing in Ears ☐Yes ☐No
Sinus Problems ☐Yes ☐No
Dental Problems ☐Yes ☐No

Breast
Lumps ☐Yes ☐No
Tenderness ☐Yes ☐No
Swelling ☐Yes ☐No
Redness ☐Yes ☐No
Nipple Discharge ☐Yes ☐No

Cardiovascular
Chest Pain ☐Yes ☐No
Irregular Heartbeat ☐Yes ☐No
Leg Swelling ☐Yes ☐No
Rapid Heartrate ☐Yes ☐No
Blood Clot ☐Yes ☐No
Shortness of Breath on Exertion ☐Yes ☐No

Respiratory
Shortness of Breath ☐Yes ☐No
Chronic Cough ☐Yes ☐No
Wheezing ☐Yes ☐No
Pain with Deep Breathing ☐Yes ☐No

Neurologic
Dizziness ☐Yes ☐No
Seizures ☐Yes ☐No
Memory Loss ☐Yes ☐No
Numbness ☐Yes ☐No

Gastrointestinal
Nausea ☐Yes ☐No
Vomiting ☐Yes ☐No
Constipation ☐Yes ☐No
Diarrhea ☐Yes ☐No
Blood in Stool ☐Yes ☐No
Heartburn ☐Yes ☐No

Genitourinary
Urgency ☐Yes ☐No
Frequency ☐Yes ☐No
Painful Urination ☐Yes ☐No
Blood in Urine ☐Yes ☐No
Nighttime Urination ☐Yes ☐No
Incontinence ☐Yes ☐No
Heavy Periods ☐Yes ☐No
Irregular Periods ☐Yes ☐No
Painful Periods ☐Yes ☐No
Bleeding with Intercourse ☐Yes ☐No
Significant PMS ☐Yes ☐No
Decreased Sex Drive ☐Yes ☐No

Integument
Rash ☐Yes ☐No
Itching ☐Yes ☐No
Abnormal Hair Growth ☐Yes ☐No

Musculoskeletal
Muscle Pain ☐Yes ☐No
Joint Pain ☐Yes ☐No
Muscular Weakness ☐Yes ☐No

Endocrine
Abnormal Thirst ☐Yes ☐No
Loss of Hair ☐Yes ☐No
Cold Intolerance ☐Yes ☐No
Heat Intolerance ☐Yes ☐No

Psychiatric
Anxiety ☐Yes ☐No
Stress ☐Yes ☐No
Depression ☐Yes ☐No
Suicidal Ideation ☐Yes ☐No

Heme-Lymph
Easy Bruising ☐Yes ☐No
Easy Bleeding ☐Yes ☐No
Enlarged Lymph Node ☐Yes ☐No
Lightheadedness ☐Yes ☐No
Blood Clotting Abnormality ☐Yes ☐No

Allergic/Immunologic
Seasonal Allergies ☐Yes ☐No
Allergic Dermatitis ☐Yes ☐No

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Risk Assessment for Hereditary Cancer Syndromes

Please mark all that apply to ***you*** and/or ***your family***, describe their relationship to you, and age of diagnosis. Consider the following family members for these questions: Mother, Father, Brother, Sister, Father's Aunt/Uncle, Mother's Aunt /Uncle, First Cousins, Niece/Nephew, Mother's Grandmother/Grandfather, Father's Grandmother/Grandfather.

Consider each question by itself, the same cancer diagnosis may apply to more than one question.

Breast and Ovarian Cancer		**Self**	**Family Member**	**Age at Diagnosis**
☐Yes ☐No	Breast Cancer before age 50			
☐Yes ☐No	Ovarian Cancer			
☐Yes ☐No	Two primary (unrelated) breast cancers in the same person or on the same side of the family.			
☐Yes ☐No	Male breast cancer			
☐Yes ☐No	Triple negative breast cancer (ER-, PR-, HER2- pathology)			
☐Yes ☐No	Pancreatic cancer with breast or ovarian cancer in the same person or on the same side of the family.			
☐Yes ☐No	Ashkenazi Jewish ancestry with breast, ovarian, or pancreatic cancer in the same person or on the same side of the family.			
Colon and Uterine Cancer				
☐Yes ☐No	Uterine (endometrial) cancer before age 50			
☐Yes ☐No	Colorectal cancer before age 50			
☐Yes ☐No	Two or more Lynch syndrome cancers* in the same person or on the same side of the family.			
*Lynch syndrome cancers include: colorectal, uterine/endometrial, ovarian, stomach, ureter/renal pelvis, biliary tract, small bowl, pancreas, brain, or sebaceous adenomas.				
Polyposis Syndromes				
☐Yes ☐No	10 or more cumulative (lifetime) colorectal adenomas (colon polyps)			
Melanoma				
☐Yes ☐No	Two or more melanomas in an individual or family.			
☐Yes ☐No	Melanoma and pancreatic cancer in an individual or family.			

Have you or any family member ever been tested for hereditary risk of cancer? If yes, please explain:_________________

____

____