advanced women's health specialists

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Name:_____ Date of Birth:_____ Today's Date:_____

Medical History (any new from last visit):

- ☐Asthma
- ☐ Arthritis
- ☐ Heart Murmur
- ☐ Heart Disease
- ☐ Stroke
- ☐ Epilepsy
- ☐ Migraines
- ☐ Lupus
- ☐ Emphysema
- ☐ Depression/Mental Illness
- ☐ High Blood Pressure
- ☐ HIV
- ☐ Kidney Disease
- ☐ Osteoporosis
- ☐ Cholesterol
- ☐ Thyroid Disease: Hyperthyroid
- ☐ Thyroid Disease: Hypothyroid
- ☐ Ovarian Cysts
- ☐ Diabetes: Type I
- ☐ Diabetes: Type II
- ☐ Polycycstic Ovaries (PCOS)
- ☐ Endometriosis
- ☐ Uterine Fibroids
- ☐ Cancer (Please specify type)
- ☐ _____
- ☐ Other:
- ☐ _____

Social History: (please circle): Single Married Divorced Widowed Female Partner Male Partner

Occupation:_____ Student: Yes No

Do you use tobacco? Yes No Previously How many packs/cigarettes per day?_____
Do you use alcohol? Yes No Previously How many drinks per day/week?_____
Do you use drugs? Yes No Previously What kind?_____ How Often?_____

OB/GYN History:

First Day of your last period:_____
Age of first period:____ How long do your periods last?_____ How many days between periods?_____
Cramping during periods? Yes No Flow: Heavy Medium Light Clots? Yes No
Are you sexually active? Yes No Never
Current sexual partner(s)? Male Female Both
Do you have a history of sexually transmitted diseases? Yes No Please specify type:_____
What do you use for contraception?_____
What have you previously used? IUD Pills Condoms Patch NuvaRing Other:_____
Date of last pap smear:_____ Normal Abnormal Date of last mammogram:_____ Normal Abnormal
Date of last colonoscopy:_____ Normal Abnormal Date of last bone density:_____ Normal Abnormal
How many times have you been pregnant?_____ Number of children:_____

Date of Delivery	Weeks at Delivery	C-Section/Vaginal	Male/Female	Baby's birth weight	Complications

Name: _____

Surgical History (any new from last visit):

Date	Type of surgery	Date	Type of surgery
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Medication (please include vitamins and over the counter medications):

Medication	Dosage (mg, IU)	How often do you take it
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies (please include medications, environmental, and food allergies):

Allergy	Reaction	Allergy	Reaction
_____	_____	_____	_____
_____	_____	_____	_____

Family Medical History (please include relationship to you – parents, siblings, grandparents):

- ☐ Diabetes: Type I _____
- ☐ Diabetes: Type II _____
- ☐ High Blood Pressure _____
- ☐ Depression/Mental Illness _____
- ☐ Thyroid Disease: Hypothyroid _____
- ☐ Thyroid Disease: Hyperthyroid _____
- ☐ Kidney Disease _____
- ☐ Osteoporosis _____
- ☐ Stroke _____
- ☐ Lupus _____
- ☐ Heart Disease _____
- ☐ Emphysema _____
- ☐ Breast Cancer _____
- ☐ Colon Cancer _____
- ☐ Ovarian Cancer _____
- ☐ Other Cancer (please specify) _____
- ☐ Other (please specify) _____

Review of Symptoms (please include any symptoms or problems you are experiencing today):

Concerns of problems you would like to discuss today: _____

- ☐ Tired/Fatigue
- ☐ Loss of Appetite
- ☐ Bleeding of Gums
- ☐ Headache
- ☐ Chest Pain
- ☐ Shortness of Breath
- ☐ Shortness of Breath with Exercise
- ☐ Nausea
- ☐ Frequent Urination at Night
- ☐ Urinary Frequency
- ☐ Urinary Urgency
- ☐ Blood in Urine
- ☐ Joint Pain
- ☐ Loss of Hair
- ☐ Memory/Concentration Difficulty
- ☐ Decreased Libido (sex drive)
- ☐ Ringing in Ears
- ☐ Vomiting
- ☐ Blood in Stool
- ☐ Intolerance to Cold
- ☐ Intolerance to heat
- ☐ Night Sweats
- ☐ Decreased Hearing
- ☐ Diarrhea
- ☐ Incontinence
- ☐ Anxiety
- ☐ Difficulty Sleeping
- ☐ Weight Loss
- ☐ Weight Gain
- ☐ Lightheadedness
- ☐ Breast Lump
- ☐ Breast Tenderness
- ☐ Nipple Discharge
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Heartburn

Hereditary Cancer Yearly Screening Questionnaire

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Please check all that apply

natera | Empower™ Hereditary cancer test

Have you or a close relative **(parents, siblings, children, uncles, aunts, first cousins, grandparents, grandchildren, nieces, nephews, or half-siblings)** had any of the following:

- ☐ **Breast cancer** diagnosed **under age 50**
- ☐ **Ashkenazi Jewish** ancestry with **breast cancer** or **prostate cancer** diagnosed at any age
- ☐ **Three or more** family members with the following cancers on the same side of the family: (breast and/or prostate) or (uterine/endometrial and/or colorectal)
- ☐ **Ovarian, uterine/endometrial, colon, pancreatic,** or male breast cancer diagnosed **at any age**
- ☐ **Metastatic (stage 4 or advanced) prostate cancer**

If you checked ANY of the boxes above, please continue to fill out the rest of the form.

Cancer site	Person (yourself or blood relative's relationship to you)	Approximate age at diagnosis	Side of the family: Mother's	Side of the family: Father's	Relative deceased?
Example: Breast Cancer	Aunt	42	X		

If you have never been diagnosed with breast cancer, please complete the following. Your answers may determine if you are eligible for enhanced breast cancer screening.

1. Height ___ft ___in **2.** Weight _____lbs **3.** Have you had children? ☐ Y ☐ N How old were you when you had your first child? _____

4. Approximate age at first menstrual period? ___ **5.** Have you gone through menopause? ☐ Y ☐ N ☐ Ongoing If yes, at approximately what age? ___

6. Are you of Ashkenazi Jewish descent? ☐ Y ☐ N

7. Have you ever used hormone replacement therapy? ☐ Y ☐ N ☐ Ongoing Start date: _____
If yes, what type? ☐ Estrogen ☐ Estrogen+Progesterone ☐ I don't know End date: _____

8. Number of relatives: Sisters: ____ Daughters: ____ Maternal aunts: ____ Paternal aunts: ____ Maternal half-sisters: ____ Paternal half-sisters: ____

9. Have you ever had a breast biopsy? ☐ Y ☐ N If yes, what was the result? ☐ Hyperplasia (no atypia) ☐ Atypical hyperplasia ☐ LCIS ☐ I don't know

10. Have you had your breast density assessed by mammogram? ☐ Y ☐ N ☐ Unknown

If known, complete ONE of the following:
☐ **VAS percentage density** _____-_____% ☐ **Volpara volumetric density** _____-_____%
☐ **BI-RADS ATLAS density:** ☐ Fatty ☐ Average ☐ Heterogeneously dense ☐ Extremely dense ☐ Unknown

Hereditary cancer testing can help you understand if you may have an increased risk for developing cancer.

I want to discuss this with my provider: ☐ Y ☐ N

Patient name: _____ Date of birth: _____

Provider you are seeing today: _____ Clinic name: _____

For more information, text **EMPOWER** to **636363**

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TELEPHONE AUTHORIZATION / PHARMACY

Patient Name: _____ **DOB:** _____

- Please indicate below the telephone number **we may use to contact you for appointment reminders, test results, return phone calls, and voicemails:**

Cell Phone: _____ ***Other Phone:*** _____

- Please indicate below **with whom we may speak with** or leave a voicemail regarding your private health information and test results **if you are unavailable:**

Name: _____ ***Phone Number:*** _____

Relationship: _____

- Please indicate with whom we may **NOT** leave a message regarding your private health information:

Name: _____ ***Relationship:*** _____

Pharmacy Name/Location/Phone Number:

_____

_____

Patient Signature: _____ **Date:** _____