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 1**
- ☐ Diabetes: **Type 2**
- ☐ Polycystic 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 currently sexually active?.....Yes No

Is your current sexual partner(s)?.....Male Female Both

Do you have a history of sexually transmitted diseases? Yes No Please specify type:_____

What do you currently 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: _____

urgical History (any new from last visit)

ate	Type of surgery	Date	Type of surgery

[edication (please include vitamins and over the counter medications):

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

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

llergy	Reaction (hives, swelling, etc)	Allergy	Reaction

amily Medical History (please include relationship to you, i.e. parents, siblings, grandparents):

Diabetes: **Type 1**_____
Diabetes: **Type 2**_____
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)
_____
_____

eview of Symptoms (Please include any symptoms or problems you are experiencing today):

oncerns of problems you would like to discuss today:_____

l Tired/Fatigue	☐ Joint Pain	☐ Incontinence
l Loss of appetite	☐ Loss of hair	☐ Anxiety
l Bleeding from gums	☐ Memory/concentration difficulty	☐ Difficulty sleeping
l Headache	☐ Decreased libido (sex drive)	☐ Weight loss
l Chest pain	☐ Ringing in ears	☐ Weight gain
l Shortness of breath	☐ Vomiting	☐ Lightheadedness
Shortness of breath with exercise	☐ Blood in stool	☐ Breast lump
Nausea	☐ Intolerance to cold	☐ Breast tenderness
Frequent urination at night	☐ Intolerance to heat	☐ Nipple discharge
Urinary frequency	☐ Night sweats	☐ Constipation
Urinary urgency	☐ Decreased hearing	☐ Hemorrhoids
Blood in urine	☐ Diarrhea	☐ Heartburn

Personal & Family Cancer History

Name: _____ Date: _____ Date of Birth: _____ Age: _____

Complete the section below. Include **yourself and all 1st and 2nd degree male and female blood relatives on both your mother's and father's sides.** Specify which relatives were affected and estimate ages of diagnosis to the best of your ability.

1st Degree Relatives: **Parents, Siblings, Children**
2nd Degree Relatives: **Grandparents, Aunts/Uncles, Nieces/Nephews**

Have you ever been tested for hereditary cancer risk? YES/NO If so, what genes were tested? Results?
(CIRCLE BELOW) _____

Have you ever been diagnosed with breast or ovarian cancer?	YES	NO
Do you have a relative who was diagnosed with **breast cancer at age 49 or younger?**	YES	NO
Do you have a relative who was diagnosed with **ovarian cancer at any age?**	YES	NO
Do you have a **MALE** relative who was diagnosed with **breast cancer at any age?**	YES	NO
Do you have a 1st degree relative who was diagnosed with **colon or uterine cancer at age 49 or younger?**	YES	NO
Do you have a 1st degree relative who was diagnosed with **pancreatic cancer at any age?**	YES	NO

Patient Signature _____

OFFICE USE ONLY
Patient offered genetic testing: Yes / No
Accepted / Declined
Provider Initials: _____

IF you have answered YES to any of the questions above, please scan the QR code below:

TELEPHONE AUTHORIZATION FORM

Patient Name: _____

Email Address: _____

Pharmacy name, location, and phone: _____

_____

Please tell us the telephone number we may use to contact you for appointment reminders, test results, return phone calls, text messages, and voice mails.

_____ ( ) Cell Phone ( ) Other _____ You agree to receive text messages

_____ ( ) Cell Phone ( ) Other _____ For office communications? ( ) **YES**

( ) **NO**

Please indicate with whom we may speak with or leave a message with regarding your private health information and test results if you are unavailable at the above numbers.

_____

Name Phone Number

Please indicate with whom you do **NOT** want us to speak with or leave a message with regarding your private health information.

_____

Name

_____

Patient Signature Date