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: _____

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 (hives, swelling, etc)	Allergy	Reaction
_____	_____	_____	_____
_____	_____	_____	_____

Family 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)
  _____
  _____

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 from 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

natera | **Empower**™ Hereditary cancer test

TODAY'S DATE:	NAME:	AGE:	DATE OF BIRTH:

Is there cancer in your family? Learn if hereditary cancer testing is right for you. For more information text EMPOWER to 636363

Is there a history of any of the following in you or your family? **Please check all that apply.** (Relatives include your parents, brothers/sisters, children, uncles, aunts, grandparents, grandchildren, nieces, nephews, or half-siblings)

Pancreatic Cancer
- ☐ Pancreatic cancer (any age)

Ovarian Cancer
- ☐ Ovarian cancer (any age)

Uterine Cancer
- ☐ Uterine cancer under age 50

Breast Cancer
- ☐ At age 50 or younger
- ☐ 2 or more breast cancers in the same person (at any ages)
- ☐ Male breast cancer (any age)
- ☐ Personal history of breast cancer (any age)

If yes, was it:
☐ Triple Negative ☐ Metastatic

Colon/Rectal Cancer
- ☐ Personal history of colon/rectal cancer (any age)
- ☐ Relative with colon/rectal cancer under age 50
- ☐ 10 or more colon polyps: Number of polyps _____

Prostate Cancer
- ☐ Metastatic (stage 4 or advanced) prostate cancer
- ☐ Personal history of prostate cancer: Gleason Score _____

- ☐ **3 family members at any age with the following cancers on the same side of the family:** breast and/or prostate, uterine/endometrial and/or colorectal
- ☐ **Ashkenazi Jewish ancestry**
- ☐ **Unknown or limited family history (adopted or less than 2 female relatives living past age 45). Please Explain:** _____
- ☐ **Known hereditary cancer gene mutation in the family. Please list gene if known:** _____
- ☐ **Other cancers not listed above**

Checked any of the boxes? If yes, please fill out the next section. Hereditary cancer testing can help you understand if you or your relatives have an increased risk for developing cancer, and help guide your medical care.

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

Please check the box if any above relative is willing to be tested ☐

Breast cancer risk assessment tool. Your answers may determine if you are eligible for enhanced breast screening:

1. Height ____ ft ____ in 2. Weight _____ lbs 3. Have you had children? ☐ Yes ☐ No How old were you when you had your first child? _____

4. Approximate age at first menstrual period? _____ 5. Have you gone through menopause? ☐ Yes ☐ No ☐ Ongoing If yes, at approximately what age? _____

6. Are you of Ashkenazi Jewish descent? ☐ Yes ☐ No

7. Have you ever used hormone replacement therapy? ☐ Yes ☐ No ☐ 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? ☐ Yes ☐ No 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? ☐ Yes ☐ No ☐ Unknown

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

Signatures

Patient Name	Patient Signature	Date
Provider Name	**Provider Signature**	**Date**

For Office Use Only

Patient offered hereditary cancer genetic testing (check all that apply)
☐ **Yes** ☐ **No** ☐ **Patient accepted** ☐ **Patient declined**

Patient previously tested ☐ **Yes** ☐ **No**

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 _____

_____ ( ) Cell Phone ( ) Other _____

You agree to receive text messages 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