unitedregional
physician group

GYN Patient paperwork

Patient Name: _____ **DOB** _____

What is the reason for your visit?

_____

Who is your family doctor? _____

What pharmacy would you like us to use for any medications prescribed?

_____

What was the first day of your last period? _____

What form of birth control or hormone replacement do you currently use?

_____

Have you ever been sexually active? YES NO

Are you currently sexually active? YES NO

Sexual partners (Past and present) Male Female Both

Have you ever received the Gardasil (HPV) vaccine? YES NO

Have you ever had a bone density scan and if so, when? _____

When was your last pap smear? _____

Have you ever had an abnormal pap? WHEN?_____

If you have had an abnormal pap, have you ever had any of the following? (please include the date)

COLPOSCOPY_____ LEEP_____ CRYO THERAPY_____

Are you having any urinary leakage? _____

When was your last mammogram? _____

When was your last colonoscopy? _____

If you are over 65, do you have an Advanced Directive? _____

Have you ever been pregnant? If **yes**, please list below.

Live Births: _____ Miscarriages: _____ Abortions: _____

Fill in information in table below for each pregnancy (whether the child is living or deceased). Please start with your first one. Also please list under delivery type if forceps or a vacuum were used.

Year	Weeks pregnant	Labor Length	Birth wt.	Sex	Type of Delivery	Name of child

Have you had any surgeries? Please list below

Surgery	Age	Year

Please list all of your current medications or provide a medication list to the nurse.

Name of medication	Dose	How many times each day?	For what condition?

Are you allergic to any medications? If **yes**, please list reaction.

Medication allergy	Allergic reaction

What do you do for work? _____

Intimate Partner Violence Screen

Within the past year, have you been afraid of your partner or ex-partner?

YES NO REFUSE TO ANSWER

Within the last year, have you been hit, kicked, slapped or otherwise physically harmed by your partner or ex-partner?

YES NO REFUSE TO ANSWER

Within the last year, have you been raped or forced to have any sexual activity by anyone?

YES NO REFUSE TO ANSWER

Social History Information

Are you adopted? **YES** **NO**

Tobacco Use: Current ____ Former ____ Never____ Type_____

Alcohol Use: Current ____ Former ____ Never ____ Type _____

Drug use: Current ____ Former ____ Never ____ Type _____

Caffeine use: Current ____ Former _____ Never ____ Type _____

Family Medical History

	Mother	Father	Sister	Brother	Maternal Grand Mother	Maternal Grand Father	Paternal Grand Mother	Paternal Grand Father
Alcoholism								
Anxiety								
Arthritis								
Asthma								
Cancer								
Diabetes								
Heart Disease								
High Cholesterol								
High Blood Pressure								
Kidney Disease								
Osteoporosis								
Seizures								
Stroke								
Thyroid Disease								

Depression Screening

In the past **2 weeks**, have you been bothered by any of the following problems? Check answer

1. **Little interest or pleasure in doing things?**

   ____ Not at all ___ Several Days ___More than half the days ___Nearly every day

2. **Feeling down, depressed or hopeless?**

   ____ Not at all ___ Several Days ___More than half the days ___Nearly every day

How hard is it for you to pay for the basic needs like food, housing, medical care or heating?

Not hard at all Not very hard Somewhat hard Hard Very hard

Within the past 12 months, have you run out of food before you had money to buy more?

YES **NO**

Within the past 12 months has lack of transportation kept you from medical appointments or from getting your medications?

YES **NO**

Within the past 12 months has lack of transportation kept you from work, meetings or getting things you needed?

YES **NO**

Do you have any of the following health problems? (Circle all that apply)

High blood pressure Irregular Heart beat Heart failure Heart attack

Asthma Emphysema COPD Sleep apnea Cancer

Acid reflux Ulcers IBS Diverticulosis Constipation

Urine Incontinence Kidney Stones Arthritis

Seizures Migraines Stroke Parkinson Dementia

Acne Eczema Psoriasis Hives

Diabetes Thyroid disease High Cholesterol Osteoporosis Gout

Anemia Blood clots

Depression Anxiety Bipolar disorder Schizophrenia

Please list any other medical issues you have currently?

_____

_____

_____

_____

_____

MYRIAD myRisk® Hereditary Cancer

Cancer Family History Questionnaire

Personal Information

Patient Name	Date of Birth	Healthcare Provider	Today's Date

Instructions: Your personal and family history of cancer is important to provide you with the best care possible. Your provider will use this information as a screening tool for cancers that run in families. Please complete the chart below based upon your personal and family history of cancer. Leave blank what you do not know.
The following relatives should be considered: Parents, siblings, half-siblings, children, grandparents, grandchildren, aunts, uncles, nieces, and nephews on both sides of the family.

Do you have a personal history of:	Yes (Y) or No (N)?	Which cancer?	Age at diagnosis?
Breast, ovarian, or pancreatic cancer at any age	☐ Y ☐ N		
Colorectal or uterine cancer at 64 or younger	☐ Y ☐ N		

Do you have a family history of:	Yes (Y) or No (N)?	Which relative?	Maternal (M) or Paternal (P) side of the family?	Age at diagnosis?
Breast cancer at 49 or younger	☐ Y ☐ N		☐ M ☐ P	
Two breast cancers (bilateral) in one relative at any age	☐ Y ☐ N		☐ M ☐ P	
Three breast cancers in relatives on the same side of the family at any age	☐ Y ☐ N		☐ M ☐ P	
Ovarian cancer at any age	☐ Y ☐ N		☐ M ☐ P	
Pancreatic cancer at any age	☐ Y ☐ N		☐ M ☐ P	
Male breast cancer at any age	☐ Y ☐ N		☐ M ☐ P	
Metastatic prostate cancer at any age	☐ Y ☐ N		☐ M ☐ P	
Colon cancer at 49 or younger	☐ Y ☐ N		☐ M ☐ P	
Uterine cancer at 49 or younger	☐ Y ☐ N		☐ M ☐ P	
Ashkenazi Jewish ancestry with breast cancer at any age	☐ Y ☐ N		☐ M ☐ P	
Do you have a family history of other cancers?	☐ Y ☐ N	List them here:		
Have you or anyone in your family had genetic testing for hereditary cancer?	☐ Y ☐ N	Who?	What gene(s)?	What was the result?

Your provider will use the following information to determine if you should consider carrier screening.

Do you plan to become pregnant in the next year?	☐ Y ☐ N	Do you have Ashkenazi Jewish ancestry?	☐ Y ☐ N

What age were you when you started your first period? _____ Age at the time of your first birth? ____

If you are menopausal, what age did you go through menopause? _____ Have you had any breast biopsies? Y / N

If you are menopausal, have you used any hormone replacement therapy? YES/NO How many years? ____

How many daughters do you have? ____ Sisters?_____Maternal Aunts?_____Paternal Aunts?_____