East Bay Women's Health, Inc.

Obstetrics Gynecology Infertility

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Patient History Form

Date:_____/ _____/_____

Name:_____ Date of Birth:____/____/____ Age:_____

Address:_____
Street City State Zip Code

Home #:_____ Cell #:_____ Work #:_____

Please select a method for us to leave confidential messages: Home Cell Work Email

Email Address: _____ Primary Care Physician:_____

Referred by:_____ Spouse/Partner:_____

Is there anything you want to discuss with your physician?

_____

_____

Medications:

Drug Name	Dosage

Allergies: drug, latex, food, environmental, etc.

Allergy	Reaction

Gynecological History

Menstrual History:
What is the first day of your last menstrual period? _____ How long does it last? _____
How many days apart are your menstrual cycles starting from the first day of one cycle to the first day of your next cycle?_____ Flow: □ Light □ Moderate □ Heavy
What age did you start having menses?_____ Are they monthly? □ Yes □ No
If postmenopausal, age at menopause: _____

Are you currently sexually active? □ No □ Yes □ Never
Sexual Orientation: Heterosexual / Lesbian / Bi-Sexual / _____ No. of Partners: _____

Are you currently using birth control? □ No □ Yes □ Trying to get pregnant
Current birth control: _____
Are you satisfied with it? □ No □ Yes

Past birth control methods:
□ Depo
□ Condoms □ Birth control pills □ Withdrawal □ Tubal Ligation
□ Diaphragm □ Patch □ Rhythm □ Vasectomy
□ Vaginal Film □ Vaginal Ring □ IUD □ Essure

Name:_____ Date of Birth:_____

Gynecological History continued

Have you ever been treated for: ☐ HPV ☐ Chlamydia ☐ Gonorrhea
☐ Genital Warts ☐ Herpes ☐ Trichomonas ☐ Syphilis

Have you ever tested positive for HIV? ☐ No ☐ Yes
Did your mother take the drug DES when she was pregnant with you? ☐ No ☐ Yes
When was your last pap smear?:_____ Result: _____
When was your last mammogram (40 and over)?:_____
Have you ever had an abnormal Pap smear? ☐ No ☐ Yes When?_____
What Abnormality?_____

Pregnancy History

	Number		Number		Number
Total times pregnant		Full term deliveries		Cesarean sections	
Miscarriages		Deliveries before 37 wks		Forceps or vacuums	
Abortions		Living children		Ectopic pregnancies	
Twins		Molar pregnancies			

Personal Medical History

Major Illnesses	**Yes**		**Yes**		**Yes**
Diabetes		Hepatitis		Asthma	
High Blood Pressure		Liver problem		Lung disease	
GI disease		Kidney infections/stones		Tuberculosis	
GI Reflux disease		Arthritis		Thyroid disease	
Osteopenia		Fracture		Clotting problem	
Osteoporosis		Seizures		Anemia	
Endometriosis		Headaches/Migraines		Psychiatric Illness	
Uterine Fibroids		Hysterectomy		Infertility	
Heart Disease		Anxiety		Anesthesia Complications	
High cholesterol		Depression		Birth defects	
Gynecological Illnesses	**Yes**		**Yes**		**Yes**
Recurrent vaginal Infection		Pelvic Infection or PID		Endometriosis	
Vaginal discharge		Itching or Odor		Ovarian Cyst	
Abnormal bleeding		Fibroids or uterine tumor		DES exposure	
Involuntary urination		Ovarian tumor			
Cancer (Type)				Varicosities	

Surgical History

Surgery	Year	Surgery	Year

Name:_____ Date of Birth:_____

Family History

Major Illnesses	**Yes**		**Yes**		**Yes**
Diabetes		Heart Disease		Anxiety	
High Blood Pressure		High cholesterol		Depression	
GI disease		Hepatitis		Seizures	
GI Reflux disease		Liver problem		Asthma	
Fibroids		Kidney infections/stones		Lung disease	
Endometriosis		Arthritis		Tuberculosis	
Osteopenia		Joint Pain		Thyroid disease	
Osteoporosis		Fracture		Clotting problem	
Neurologic Problems		Bleeding Disorders		Stroke	
Alzheimer's		Anemia		Alcohol Abuse	
Psychiatric problems		Cancer (Type)			
Please Identify Family Relation to Major Illness:					

Social History

Birth Place:_____ Ethnicity:_____

Marital status: □ Married □ Divorced □ Single □ Widowed
□ Significantly Involved □ Domestic Partner

Education: □ <8th grade □ High School □ Some College □ College □ Post graduate

Occupation:_____

Habits

Smoking: □ Yes □ No Packs/day_____ Years_____ Quit when:_____
Alcohol: □ Yes □ No Drinks/day_____ Drinks/week_____ Quit when:_____
Drug Use: □ Yes □ No Type_____ Years_____ Quit when:_____
Caffeine: □ Yes □ No Cups per day_____ Cups per week_____
Diet: □ Regular □ Vegetarian □ Vegan □ Gluten free □ Specific □ Cardiac □ Carbohydrate
General Stress Level: □ Low □ Medium □High
Exercise Level: □ None □ Occasional □ Moderate □ Heavy

Personal Safety

□ Yes □ No Has anyone close to you ever threatened to hurt you?
□ Yes □ No Has anyone ever hit, kicked, choked or hurt you physically?
□ Yes □ No Has anyone, including your partner, ever forced you to have sex?
□ Yes □ No Are you ever afraid of your partner?

Name:_____ Date of Birth:_____

Review of Systems

Please check if you note symptoms of:

1. Constitutional		Notes
Fever	☐	
Chills	☐	
Fatigue	☐	
Weight loss	☐	
Weight gain	☐	
2. Eyes		
Change in vision	☐	
Double vision	☐	
3. ENT/Mouth		
Ear aches	☐	
Ringing in the ears	☐	
Sinus problems	☐	
Sore throat	☐	
Mouth sores	☐	
Dry Mouth	☐	
4. Cardiovascular		
Chest pain	☐	
Difficulty breathing on exertion	☐	
Swelling of legs	☐	
Palpitations	☐	
Heart Murmurs	☐	
5. Respiratory		
Wheezing	☐	
Spitting up blood	☐	
Shortness of breath	☐	
Cough	☐	
6. Gastrointestinal		
Diarrhea	☐	
Constipation	☐	
Nausea/vomiting	☐	
Bloody stool	☐	
Abdominal pain	☐	
Indigestion	☐	
Bloating	☐	
Liver problem/Hepatitis	☐	
7. Genitourinary		
Blood in urine	☐	
Pain with urination	☐	
Urgency	☐	
Urinary Frequency	☐	
Urinary Incontinence	☐	

7. Genitourinary (cont.)		Notes
Abnormal bleeding	☐	
Vaginal discharge/odor	☐	
Vaginal itching/burning	☐	
Pelvic pain	☐	
Menstrual cramps	☐	
Painful intercourse	☐	
Genital lump	☐	
Fertility concerns	☐	
Menopausal concerns	☐	
8. Musculoskeletal		
Muscle weakness	☐	
Joint stiffness	☐	
Joint pain	☐	
Joint swelling	☐	
9. Skin/Breast		
Breast pain	☐	
Nipple discharge	☐	
Breast lumps	☐	
Rash	☐	
Ulcers	☐	
10. Psychiatric		
Depression	☐	
Mood swings	☐	
Anxiety	☐	
Suicidal thoughts	☐	
Homicidal thoughts	☐	
11. Endocrine		
Abnormal thirst	☐	
Hot flashes	☐	
Tremors	☐	
Cold/heat intolerance	☐	
12. Hematologic		
Frequent bruising	☐	
Cuts do not stop bleeding	☐	
Enlarged lymph nodes	☐	
13. How tall are you?		

Please bring the above to the attention of your Primary Care Physician if not addressed today.

Family History Questionnaire for Common Hereditary Cancer Syndromes

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

Please mark below if there is a **personal or family history** of any of the following cancers. If yes, then indicate family relationship and age at diagnosis in the appropriate column. Consider parents, children, brothers, sisters, grandparents, aunts, uncles, and cousins.

Example: Colon Cancer *Brother 36 yrs* *Aunt 44 yrs* *Grandfather 65 yrs* *Cousin 58 yrs*

BREAST AND OVARIAN CANCER

			You	Siblings / Children	Mother's Side	Father's Side
Y	**N**	Breast cancer				
Y	**N**	Ovarian cancer				
Y	**N**	Breast cancer in both breasts OR multiple primary breast cancers				
Y	**N**	Male breast cancer				
Y	**N**	Are you of Ashkenazi Jewish descent?				

COLON AND UTERINE CANCER

			You	Siblings / Children	Mother's Side	Father's Side
Y	**N**	Uterine (endometrial) cancer				
Y	**N**	Colon cancer				
Y	**N**	Ovarian, stomach, kidney/urinary tract, brain OR small bowel cancer				
Y	**N**	10 or more colon polyps found in a lifetime				

OTHER CANCERS

			You	Siblings / Children	Mother's Side	Father's Side
Y	**N**	Prostate cancer				
Y	**N**	Pancreatic cancer				
Y	**N**	Melanoma				
Y	**N**	OTHER:_____				

Red Flags for HBOC (BRACAnalysis)

- **Breast cancer at or before 50**
- **Ovarian cancer at any age**
- **Two primary breast cancers in an individual or family**
- **Male breast cancer at any age**
- **Triple-negative (ER, PR, Her2 neg) at or before 60**
- **Pancreatic cancer with breast and/or ovarian cancer**
- **Ashkenazi Jewish with breast or ovarian cancer at any age**
- **Two or more relatives with breast cancer, one before 50.**
- **Three or more relatives w/ breast cancer at any age.**
- **Known mutation in the family.**

Red Flags for Lynch Syndrome (Colaris)

- **Colorectal cancer under 50.**
- **Endometrial caner under 50.**
- **Two or more Lynch cancers at any age (see list below)**
- **Two or more relatives with a Lynch cancer, one under 50.**
- **Three or more relatives with Lynch cancers at any age.**
- **Known mutation in the family.**

Lynch cancers include: colon, endometrial, ovarian, gastric/stomach, ureter/renal pelvis, biliary tract, small bowel, pancreas, brain, sebaceous adenoma.

Patient's Signature:_____ Date: _____

Health Care Provider's Signature: _____ Date: _____

For Office Use Only:

Follow-up appointment scheduled: YES NO Date of Appointment:_____

Patient offered hereditary cancer testing? ACCEPTED DECLINED N/A

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RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

I, _____, have read / received a copy of East Bay Women's Health, Inc.'s
Printed Patient Name

Notice of Privacy Practices.

_____ _____
Signature of Patient Date