ARROWHEAD OBSTETRICS & GYNECOLOGY

Name - Last, First, Mi	Date of Birth:	Today's Date:
Occupation:	Marital Status:	Age:

What brings you in today?

1. How old were you when you started having periods? _____
2. What day did your last period start? _____
3. How many days does your period normally last? _____ How many days between periods? _____
4. Describe your menstrual flow - check one: ☐ light ☐ Moderate ☐ heavy Clots? ☐ yes ☐ no
5. Are you presently sexually active? ☐ Yes ☐ No If no, have you been sexually active in the past? _____
6. Are you using anything to prevent pregnancy? ☐ Yes ☐ No If yes which method? _____
7. Have you ever had a sexually transmitted disease? ☐ Yes ☐ No
8. If yes to #7 - please check and give date of diagnosis: ☐ Herpes: _____ ☐ Genital Warts: _____
   ☐Gonorrhea: _____ ☐ Syphillis: _____ ☐ Chlamydia: _____ ☐ Other: _____
9. Do you smoke? ☐ Yes ☐No In the past? ☐ Yes ☐No Packs per day? _____ How long? _____
10. Do you use alcohol? ☐ Yes ☐ No
11. Have you ever been pregnant? ☐ Yes ☐ No If yes, please list all pregnancies with outcome:

A - Abortion M - Miscarriage V - Vaginal delivery C - Cesarean delivery

	Month/Year	Outcome	Complications		Month/Year	Outcome	Complications
1				8			
2				9			
3				10			
4				11			
5				12			
6				13			
7				14			

Lab Testing:

	When?	Where?	History of Abnormal Results
Mammogram			
Chest X-ray			
Cholesterol			
Pap Smear			

Drug Allergies: If yes please list the reason.

_____

_____

Medications: Including prescription and over the counter

Past Medical History

	Anemia		Heart Disease		Thyroid Disease		Please List others
	Arthritis		Heart Murmur		Tuberculosis		
	Asthma		Hepatitis		Ulcers		
	Blood Transfusion		High Cholesterol		Osteoporosis		
	Depression / Anxiety		High Blood Pressure		Herpes		
	Diabetes		Kidney Infections		Mental Illness		
	Glaucoma		Seizures				

Past Surgeries

Past Surgery	Date	Past Surgery	Date

Medication Allergies / Food Allergies

Drug Food Allergy	Reaction	Drug Food Allergy	Reaction

Please check (X) if any of the following symptoms apply to you <u>currently</u>

Constitutional		**Cardiovascular**		**Skin**	
	Weight Loss		Painful Breathing		Rash
	Weight Gain		Chest Pain		Ulcers
	Fever		Difficult Breathing on Exertion	**Neurologic**	
	Fatigue		Swelling of Legs		Dizziness
Eyes			Palpitations of Heart		Seizures
	Double Vision	**Respiratory**			Numbness
	Spots Before Eyes		Wheezing		Trouble Walking
	Vision Changes		Spitting Up Blood	**Musculoskeletal**	
Ear, Nose, Throat			Shortness of Breath		Muscle Weakness
	Ear Aches		Cough, Chronic	**Endocrine**	
	Ringing in Ears	**Gastrointestinal**			Dry Skin
	Sinus Problems		Frequent Diarrhea		Abnormal Thirst
	Sore Throat		Bloody Stool		Hot Flashes
	Mouth Sores		Nausea/Vomiting	**Psychiatric**	
	Dental Problems		Constipation		Depression
Breasts		**Genitourinary**			Frequent Crying
	Pain in Breast		Blood in Urine	**Hematological / Lymphatic**	
	Discharge		Pain with Urination		
	Masses		Urgency		
			Frequency of Urination		
			Incomplete Urination		
			Stress Incontinence		
			Abnormal Periods		
			Painful Intercourse		

Family Medical History

Condition:	Yes	Relative	Maternal	Paternal
Alcoholism				
Colon Cancer				
Breast / Ovarian Cancer				
Diabetes				
High Blood Pressure				
Heart Disease				
Stroke				

This is a screening tool for cancers that run in families. Please consider these family members when completing the form.

Mother / Father / Sister / Brother / Children = **1st Degree Relatives**
Aunt / Uncle / Grandparent / Niece / Nephew = **2nd Degree Relatives**
Cousin / Great Grand Parent = **3rd Degree Relatives**

Have you or any of your relatives been tested for hereditary cancer (BRCA/Colaris) in the past? ☐ Yes ☐ No

		COLON AND UTERINE CANCER (Lynch Syndrome/Colaris)	Self	Your Relationship To Family Member w/ Cancer		Age At Diagnosis
				Mother's Side	Father's Side	
Y	N	***EXAMPLE**: Two or more relatives with a Lynch Syndrome **cancer; one under age 50***			*Aunt - Colon* *Sister - Uterine*	*47 yrs* *60yrs*
Y	N	Have you been diagnosed with uterine (endometrial) or colorectal cancer before age 50				
Y	N	Two or more relatives on the same side of the family w/any of the following, one diagnosed before 50 (please circle): *colon, uterine / endometrial, ovarian, stomach, small bowel, brain, kidney / urinary tract, ureter and renal pelvis*				
Y	N	Three or more relatives on the same side of the family w/any of the following diagnosed at any age (please circle): *colon, uterine / endometrial, ovarian, stomach, small bowel, brain, kidney / urinary tract, ureter and renal pelvis*				
Y	N	Family member has a known Lynch syndrome mutation				

		BREAST AND OVARIAN CANCER (HBOC/BRACAnalysis)	Self	Your Relationship To Family Member w/ Cancer		Age At Diagnosis
				Mother's Side	Father's Side	
Y	N	Breast cancer at age 45 or younger (in self, first or second degree family members)				
Y	N	Ovarian cancer at any age (in self, first or second degree family members)				
Y	N	Two relatives on the same side of family with breast cancer with one under the age of 50				
Y	N	Three relatives or more on the same side of the family with breast cancer at any age				
Y	N	Multiple breast cancers in the same person (in the same breast or in both breasts)				
Y	N	Male breast cancer at any age				
Y	N	Ashkenazi Jewish ancestry with breast or ovarian or pancreatic cancer in the same person or on the same side of the family				
Y	N	Pancreatic cancer with breast or ovarian cancer in the same person or on the same side of the family				
Y	N	Triple Negative breast cancer under age 60 (ER, PR, and Her 2 negative receptor status)				
Y	N	A family member with a known BRCA mutation				

Is there any other cancer in you or your family members not listed above (provide site, relationship and age):

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