Ivinson MEMORIAL HOSPITAL
MEDICAL GROUP

Derek Ewell, DO
Obstetrics/Gynecology

Elizabeth Rowe
Certified Nurse Midwife

Samantha Herriott, DO
Obstetrics/Gynecology

Kim Westbrook, MD
Obstetrics/Gynecology

Patient Paperwork

Patient Information

Name: _____
LAST FIRST M.I.

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

Phone: (_____) _____ Preferred Contact Method:
email phone text mail

Employer:_____ Occupation: _____

Current Medications

MEDICATION	DOSE	HOW OFTEN

Allergies

MEDICATION	REACTION

Do you have any other allergies (latex, iodine, food or environment)?

_____

_____

Surgical History

SURGERY	DATE/YEAR	COMPLICATIONS

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Reason for today's visit: _____

Medical History

Do you have any health problems? (check all that apply)

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Bladder or Kidney Problems
- ☐ Blood Clots or Stroke
- ☐ History of Blood Transfusion
- ☐ Breast Problems
- ☐ Depression
- ☐ Stomach or Bowel Problems
- ☐ Heart Problems
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Lung Problems
- ☐ Migraine Headaches
- ☐ Neurologic Problems
- ☐ Polycystic Ovarian Syndrome
- ☐ Seasonal Allergies
- ☐ Serious Injuries / Accidents
- ☐ Thyroid Problems
- ☐ Stomach Ulcers
- ☐ Other:_____
- ☐ Other:_____

Please explain and checked boxes

_____

_____

_____

Family History

Is your father alive? Yes *No Age_____

*If deceased, at what age and reason for death: _____

Did he have any other medical problems? _____

Is your mother alive? Yes *No Age_____

*If deceased, at what age and reason for death:_____

Did she have any other medical problems? _____

Do any of your immediate family members have any of the following, please include: siblings, parents, grandparents.

Medical Condition	Yes	No	Who (immediate family members)
Cancer (type)			
Blood Clot/Stroke			
Diabetes			
Heart Disease			
High Blood Pressure			
Thyroid Problems			
Other			

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Are there any genetic or inherited health problems in your family? If so, what was it and how were they related to you?

_____

_____

_____

Immunization History	
DATE RECEIVED	IMMUNIZATION
	Tdap (Tetanus, diphtheria and pertussis-whooping cough)
	Tetanus
	Pneumonia Vaccine (PCV 23)
	Prevnar (PVC 13)
	Zostavax (Shingles)
	Influeza (flu)
	Gardasil (HPV)

Health Maintenance	
DATE RECEIVED	IMMUNIZATION
	Bone Density (DEXA Scan)
	Mammogram
	Pap Smear
	Wellness Labs
	Colonoscopy

Social History

Marital Status: Single Married Divorced Separated Widowed

Do you smoke cigarettes or e-cigarettes? No *Yes
*How much? _____ *How many years? _____ *Former Smoker, when did you quit? _____

Do you use chewing tobacco, snuff, or other forms of tobacco? No *Yes
*Please list what type:_____

Do you use recreational drugs (marijuana, etc.)? No *Yes
*Please list what type:_____

Do you drink alcohol? No *Yes
*How many glasses of wine/liquor, mixed drinks/beer per week? _____

What is your highest level of education? Grade School High School College Other

Gynecologic History

When was the first day of your last menstrual period? _____ / _____ /_____

If postmenopausal, at what age did your periods stop? _____

* If you answered this question, please skip the following questions regarding your cycle*

What age was your first menstrual period? _____

How many days from the start of the period to the start of the next period? _____

How many days to they typically last? _____ Is your flow light moderate heavy

Do you have painful periods? Yes No Do you bleed/spot between periods? Yes No

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Gynecologic History, cont.

When was your last pap smear? _____/_____/_____

Was it normal? Yes No

Have you ever had an abnormal pap smear? Yes No If so, when? ____/____/_____

Have you ever had a procedure for an abnormal pap smear? Yes No
If so, when? ____/____/____ What procedure? _____

Do you have breast implants? Yes No

When was your last mammogram? _____/_____/_____

Was it normal? Yes No

Have you ever had an abnormal mammogram? Yes No If so, when? ____/____/____

Have you ever had a breast biopsy? Yes No If so, when? ____/____/____

Are you sexually active? Yes No What are you using for contraception? _____

How many sexual partners have you had in your lifetime?_____
Have your sexual partners been? Men Women Both

Have you ever had a sexually transmitted infection? Yes No
If yes, which one/s? _____ When: _____/_____/_____

Have you ever been a victim of abuse? *Yes No *Check all that apply: physical sexual verbal

Pregnancy History

**Please list the total number next to each category*

Total number of pregnancies (including miscarriages and terminations): _____
Miscarriage (loss before 20 weeks): _____ Pregnancy Terminations: _____
Live Births: _____
Full Term deliveries (37 weeks or more): _____ Preterm deliveries (20 – 37 weeks): _____
Vaginal deliveries: _____ Cesarean deliveries: _____

Living Children: _____ Adopted: _____ Deceased Children: _____ Stillborn: _____

Did you have any complications with your pregnancies? _____

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*Please mark yes (circle, check, or X) for any **current symptoms** you may have.*

CONSTITUTIONAL		
Weight Gain	Yes	No
Weight Loss	Yes	No
Fatigue	Yes	No
Hot Flashes	Yes	No
Night Sweats	Yes	No

EYES		
Double Vision	Yes	No
Blurred Vision	Yes	No

HENT		
Sore throat	Yes	No
Headaches	Yes	No
Nasal congestion	Yes	No
Ringing in ears	Yes	No
Sinus problems	Yes	No
Dental problems	Yes	No

BREAST		
Lumps	Yes	No
Tenderness	Yes	No
Swelling	Yes	No
Redness	Yes	No
Nipple discharge	Yes	No

CARDIOVASCULAR		
Chest pain	Yes	No
Irregular heart beats	Yes	No
Leg swelling	Yes	No
Rapid heart rate	Yes	No
Blood clot	Yes	No
Shortness of breath on exertion	Yes	No

RESPIRATORY		
Shortness of breath	Yes	No
Chronic cough	Yes	No
Wheezing	Yes	No
Pain with deep breathing	Yes	No

NEUROLOGIC		
Dizziness	Yes	No
Seizures	Yes	No
Memory Loss	Yes	No
Numbness	Yes	No

GASTROINTESTINAL		
Nausea	Yes	No
Vomiting	Yes	No
Constipation	Yes	No
Diarrhea	Yes	No
Blood in stool	Yes	No
Heartburn	Yes	No

GENITOURINARY		
Urgency	Yes	No
Frequency	Yes	No
Painful urination	Yes	No
Blood in urine	Yes	No
Night time urination	Yes	No
Incontinence	Yes	No
Heavy periods	Yes	No
Irregular periods	Yes	No
Painful periods	Yes	No
Bleeding with intercourse	Yes	No
Significant PMS	Yes	No
Decreased Sex Drive	Yes	No

INTEGUMENT		
Rash	Yes	No
Itching	Yes	No
Abnormal hair growth	Yes	No

MUSCULOSKELETAL		
Muscle pain	Yes	No
Joint pain	Yes	No
Muscular weakness	Yes	No

ENDOCRINE		
Abnormal thirst	Yes	No
Loss of hair	Yes	No
Cold intolerance	Yes	No
Heat intolerance	Yes	No

PSYCHIATRIC		
Anxiety	Yes	No
Stress	Yes	No
Depression	Yes	No
Suicidal ideation	Yes	No

HEME-LYMPH		
Easy bruising	Yes	No
Easy bleeding	Yes	No
Enlarged lymph node	Yes	No
Lightheadedness	Yes	No
Blood clotting abnormality	Yes	No

ALLERIC - IMMUNOLOGIC		
Seasonal allergies	Yes	No
Allergic dermatitis	Yes	No

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Risk Assessment for Hereditary Cancer Syndromes

Please circle Y for those that apply to YOU and/or YOUR FAMILY (on both your mother's/maternal or father's/paternal side). Next to each statement, please list the relationship to you and age of diagnosis.

The following family members and yourself should be considered for the questions below:					
Mother	Father	Brother	Sister	Paternal Uncle/Aunt	Maternal Uncle/Aunt
First Cousins	Niece/Nephew	Maternal Grandmother/Grandfather		Paternal Grandmother/Grandfather	

Each statement should be answered individually, so you may list the same cancer diagnosis more than once as you answer these questions. This is a screening tool for the common features of hereditary cancer syndromes. Share this information with your healthcare professional to help determine your hereditary cancer risk.

		BREAST AND OVARIAN CANCER	SELF	FAMILY MEMBER	AGE OF DIAGNOSIS
Y	N	Breast Cancer before age 50			
Y	N	Ovarian Cancer			
Y	N	Two primary (unrelated) breast cancers in the same person or on the same side of the family			
Y	N	Male breast cancer			
Y	N	Triple negative breast cancer (ER-, PR-, HER2- pathology)			
Y	N	Pancreatic cancer with breast or ovarian cancer in the same person or on the same side of the family			
Y	N	Ashkenazi Jewish ancestry with breast, ovarian or pancreatic cancer in the same person or on the same side of the family			
		COLON AND UTERINE CANCER	**SELF**	**FAMILY MEMBER**	**AGE OF DIAGNOSIS**
Y	N	Uterine (endometrial) cancer before age 50			
Y	N	Colorectal cancer before age 50			
Y	N	Two or more Lynch syndrome cancers* in the same person or on the same side of the family.			

*Lynch syndrome cancers include: colorectal, uterine/endometrial, ovarian, stomach, ureter/renal pelvis, biliary tract, small bowl, pancreas, brain, or sebaceous adenomas)

		POLYPOSIS SYNDROMES	SELF	FAMILY MEMBER	AGE OF DIAGNOSIS
Y	N	10 or more cumulative (lifetime) colorectal adenomas (colon polyps)			
		MELANOMA	**SELF**	**FAMILY MEMBER**	**AGE OF DIAGNOSIS**
Y	N	Two or more melanomas in an individual or family			
Y	N	Melanoma and pancreatic cancer in an individual or family			
Y	N	Have you or any member of your family ever been tested for hereditary risk of cancer? If yes please explain: _____ _____			