Locust Grove Women's Health

Established Patient Yearly Exam

Name_____Date of Birth_____

What are you hoping to accomplish at today's visit?

_____

_____

_____

Date of the first day of your last menstrual period (or year of last menses if you are post-menopausal):

_____

How often do your periods come? □ NA

_____

How long do they last? □ NA

_____

Do you have very heavy periods? □ Yes □ No

Do you have period pain you would like us to address? □ Yes □ No

Do you bleed between your periods (or have you had bleeding since menopause began)? □ Yes □ No

Are you planning a pregnancy in the next year? □ Yes □ No

Are you sexually active? □ Yes □ No

With Men □ Women □ Both □

Are you having any pain or problems with sexual activity that you would like to discuss? □ Yes □ No

How many partners have you had in the last 12 months?

_____

In your lifetime? _____

Are you doing anything to prevent pregnancy? □Yes □No, □NA

If yes, what?

□ Birth control pills
□ Birth control patch
□ IUD
□ Tubal ligation
□ Rhythm method
□ Diaphragm/Cap
□ Nuva-ring
□ Condoms
□ Vasectomy
□ Withdrawal
□ Spermicide
□ Other

_____

Are you interested in a different method? □ Yes □ No

If yes, what?_____

Are you using Estrogen replacement or Hormone replacement? □ Yes □ No

If yes, what?_____

Have there been any changes to your health since your last wellness exam? Have you had surgery? Have you been diagnosed with a new problem? New STD?

Please describe:_____

_____

_____

_____

_____

_____

_____

Health care maintenance:

Since your last wellness visit with us, have you had a pap test, mammogram, colonoscopy, bone density study, cholesterol test, or diabetes test? Please list below, including approximate date and result.

_____

_____

_____

_____

_____

Immunizations:

Date of last tetanus booster:_____

Do you get annual flu shots: □ Yes □ No

Have you had the following vaccinations?

□ Gardasil (HPV)
□ Hepatitis A
□ Pneumonia
□ Hepatitis B
□ Meningitis
□ Other

_____

Have any family members developed new medical problems since your last wellness exam?

Please describe:_____

_____

_____

_____

Do you take any prescription or OTC medications, vitamins or supplements? Please list them:

Medication Dose Frequency

_____

_____

_____

_____

_____

_____

_____

_____

_____

Have you had a new reaction to any medications, foods, or environmental substances since your last wellness exam?

Please describe:_____

_____

_____

_____

_____

_____

Please turn over for side two.....

What is your occupation?

_____

_____

Do you drink alcohol? □ Yes □ No

If yes, how many servings weekly (one serving is 12 oz of beer, 5 oz of wine, or 1 oz of hard alcohol)?_____

Have you ever felt you should cut down on your drinking? □ Yes □ No

Have people ever annoyed you by nagging you about your drinking? □ Yes □ No

Have you ever felt guilty about your drinking? □ Yes □ No

Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover? □ Yes □ No

Do you currently use recreational drugs? □ Yes □ No

Have you previously injected or snorted recreational drugs? □ Yes □ No

Do you use tobacco now? □ Yes □ No

If yes, are you planning to quit this year? □ Yes □ No

If you used to smoke, what year did you quit?

_____

If you currently smoke, or used to smoke:

Number of packs per day used:_____

Number of years smoked:_____

Do you exercise: □ Yes □ No

What kind?_____

How often?_____

Are you following a specific/special diet? □ Yes □ No

Please describe:_____

How many servings of dairy do you eat each day?_____

How many servings of fruits and vegetables do you eat each day?_____

How often do you eat out?_____

Are you careful about the fat content of your diet? □ Yes □ No

Do you always wear your seat belt? □ Yes □ No

Do you have a working smoke detector in your home? □ Yes □ No

Have you had a dental check-up in the last year? □ Yes □ No

In your family or relationships, is conflict sometimes handled by pushing, hitting, or cruelty? □ Yes □ No

Have you often felt down, depressed, or hopeless in the last month? □ Yes □ No

Have you often had little interest or pleasure in doing things in the last month? □ Yes □ No

If any of the following symptoms are currently bothering you, please circle them:

Unintended weight loss or gain, fevers, night sweats, extreme fatigue

Changes in your vision, eye pain or discharge

Problems hearing, ear pain, mouth pain, throat pain, sinus pain or discharge

Breast lump or changes

Chest pain, irregular heartbeats, swelling of your feet or ankles, shortness of breath at night

Cough, wheezing, unusual shortness of breath during normal activities or during exercise

Nausea, vomiting, diarrhea, changes in your stools or bowel habits, stomach pain

Pain with urinations, leaking urine, blood in urine, unusual vaginal discharge

Rash or unusual mole

Severe headache, numbness or unusual weakness

Joint swelling or pain, unusual muscle pain

Feeling unusually hot or cold

Unusual bleeding or bruising, swollen glands

Hives, frequent unusual illness

What are your goals for your health:

In the next year?

_____

_____

In the next 5 years?

_____

_____

In the next 15 years?

_____

_____

How can we help you accomplish these goals?

_____

_____

_____

_____

_____

_____

_____

Physician's Signature

_____

Date

CANCER FAMILY HISTORY QUESTIONNAIRE

Personal Information

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

Gender (M/F): _____ **Today's Date(MM/DD/YY):** _____ **Health Care Provider:** _____

Instructions: This is a screening tool for cancers that run in families. Please mark (Y) for those that apply to YOU and/or YOUR FAMILY. Next to each statement, please list the relationship(s) to you and age of diagnosis for each cancer in your family.

You and the following close blood relatives should be considered: *You, Parents, Brothers, Sisters, Sons, Daughters, Grandparents, Grandchildren, Aunts, Uncles, Nephews, Nieces, Half-Siblings, First-Cousins, Great-Grandparents and Great Grandchildren*

YOU and YOUR FAMILY's Cancer History (Please be as thorough and accurate as possible)

	CANCER	YOU AGE OF Diagnosis	PARENTS / SIBLINGS / CHILDREN	AGE OF Diagnosis	RELATIVES on your MOTHER'S SIDE	AGE OF Diagnosis	RELATIVES on your FATHER'S SIDE	AGE OF Diagnosis
☑Y ☐N	*EXAMPLE: BREAST CANCER*	*45*	-------	---	*Aunt Cousin*	*45 61*	*Grandmother*	*53*
☐Y ☐N	BREAST CANCER *(Female or Male)*							
☐Y ☐N	OVARIAN CANCER *(Peritoneal/Fallopian Tube)*							
☐Y ☐N	UTERINE (ENDOMETRIAL) CANCER							
☐Y ☐N	COLON/RECTAL CANCER							
☐Y ☐N	10 or more LIFETIME COLON POLYPS *(Specify #)*							
☐Y ☐N	OTHER CANCER(S) *(Specify cancer type)*	Among others, consider the following cancers: *Melanoma, Pancreatic, Stomach (Gastric), Brain, Kidney, Bladder, Small bowel, Sarcoma, Thyroid, Prostate*						

☐ Y ☐ N Are you of Ashkenazi Jewish descent?

☐ Y ☐ N Are you concerned about your personal and/or family history of cancer?

☐ Y ☐ N Have you or anyone in your family had genetic testing for a hereditary cancer syndrome? *(Please explain/include a copy of result if possible)*

Hereditary Cancer Red Flags (To be completed with your healthcare provider - Check all that apply)

Hereditary Breast and Ovarian Cancer Syndrome - Red Flags*

Personal and/or family history† of:

- ☐ Breast cancer diagnosed before age 50
- ☐ Ovarian cancer
- ☐ Two primary breast cancers
- ☐ Male breast cancer
- ☐ Triple Negative Breast Cancer
- ☐ Ashkenazi Jewish ancestry with an HBOC-associated cancer‡§
- ☐ Three or more HBOC-associated cancers at any age‡§
- ☐ A previously identified HBOC syndrome mutation in the family

†Close blood relatives include first-, second-, or third-degree in the maternal or paternal lineage
‡In the same individual or on the same side of the family
§HBOC-associated cancers include breast (including DCIS), ovarian, pancreatic, and aggressive prostate cancer

Lynch Syndrome - Red Flags*

An individual with any of the following:

- ☐ Colorectal or endometrial cancer before age 50
- ☐ MSI High histology before age 60¶
- ☐ Abnormal MSI\IHC tumor test result (colorectal/endometrial)
- ☐ Two or more Lynch syndrome cancers** at any age
- ☐ Lynch syndrome cancer** with one or more relatives with a Lynch syndrome cancer^
- ☐ A previously identified Lynch syndrome or MAP syndrome mutation in the family

An individual with any of the following family histories:

- ☐ A first- or second-degree relative with colorectal or endometrial cancer before age 50
- ☐ Two or more relatives with a Lynch syndrome cancer**, one before the age of 50^
- ☐ Three or more relatives with a Lynch syndrome cancer** at any age^
- ☐ A previously identified Lynch syndrome or MAP syndrome mutation in the family

¶MSI High histology includes: Mucinous, signet ring, tumor infiltrating lymphocytes, Crohn's-like lymphocytic reaction, or medullary growth pattern
***Lynch syndrome-associated cancers include colorectal, endometrial, gastric, ovarian, ureter/renal pelvis, biliary tract, small bowel, pancreas, brain, sebaceous adenomas*
^Cancer history should be on the same side of the family

**Assessment criteria are based on medical society guidelines. For individual medical society guidelines, go to www.MyriadPro.com*

Cancer Risk Assessment Review (To be completed after discussion with healthcare provider)

Patient's Signature: _____ Date: _____

Health Care Provider's Signature: _____ Date: _____

For Office Use Only: Patient offered hereditary cancer genetic testing? ☐ YES ☐ NO ☐ ACCEPTED ☐ DECLINED

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