Stony Brook Medicine

Hamptons Gynecology and Obstetrics

Name: _____ Date of Birth: _____

Address: _____ City: _____ Zip: _____ Phone #: _____

Cell #: _____ Today's Date: _____

Primary Care Doctor:	**Reason for Visit:**

PERSONAL HISTORY		
Height:	**Weight:**	**Age:**
Allergies to Medications (list):	Current Medications (list):	Vitamins (list):
Exercise: ☐ How often:	**Cigarettes:** ☐ How often:	**Alcohol:** ☐ How often:
Marital Status: Married ☐ Single ☐ Divorced ☐	**Sexually Active:** Yes ☐ No ☐ With: Men ☐ Women ☐ Both ☐	
Occupation:		
Race: White ☐ African American ☐ Hispanic ☐ Asian ☐ Native American ☐ Other ☐		
Age Periods Began: How Frequent?	Avg. Length of Period (days):	Last Menstruation: ___/___/___	Menopause age:
Last Pap Smear: ___/___/___	Last Mammogram: ___/___/___	Last Colonoscopy: ___/___/___	Bone Density: ___/___/___
Do you take birth control? Yes ☐ No ☐	Birth control method or prescription: _____		

PERSONAL MEDICAL HISTORY, Check ALL that apply:		OR NONE ☐
Diabetes ☐	High Blood Pressure ☐	Asthma ☐
Heart Failure/Heart Attack ☐	Lung Disease ☐	Hepatitis ☐
Heart Disease/Murmur ☐	Gall Bladder Disease ☐	Thyroid Disease ☐
Bleeding Abnormality ☐	Eating Disorder ☐	Breast Cancer ☐
Depression ☐	Migraines ☐	Breast Disease/Biopsy ☐
Osteoporosis ☐	Kidney Disease ☐	Other Disease or Cancers ☐
If "Other" please list:		

TREATMENT HISTORY, Check ALL that apply:		OR NONE ☐
STDs ☐	Abnormal Pap Smears ☐	Infertility ☐
Fibroids (of the uterus) ☐	Ovarian Cysts ☐	Endometriosis ☐

PREGNANCY HISTORY						OR NONE ☐
	Date of Birth	Birth Weight	Check	Weeks	Delivery Type	Complications?
1			Boy ☐ Girl ☐		Vaginal ☐ C-Section ☐	
2			Boy ☐ Girl ☐		Vaginal ☐ C-Section ☐	
3			Boy ☐ Girl ☐		Vaginal ☐ C-Section ☐	
4			Boy ☐ Girl ☐		Vaginal ☐ C-Section ☐	
# of Abortions: ___		Date: ___	# of Miscarriages: ___		Currently trying to get pregnant? Yes ☐ No ☐	

PERSONAL SURGERY HISTORY
List <u>ANY</u> surgeries you've had:

The Following Relatives Should Be Considered:

You, Mother, Father, Brother, Sister, Children, Paternal Aunt/Uncle, Maternal Aunt/Uncle, Half-Siblings, First Cousins, Nieces/Nephews, Maternal & Paternal Grandparents, Great Aunts/Uncles

Name: _____ Doctor: _____ Date: _____

Family History				
Disease Type	**Check**	**List All Relatives (see list above)**		**Paternal/Maternal**
Heart Attack	Yes ☐ No ☐			
Stroke	Yes ☐ No ☐			
Blood Clots (other than stroke)	Yes ☐ No ☐			
Diabetes	Yes ☐ No ☐			
Depression	Yes ☐ No ☐			
Osteoporosis	Yes ☐ No ☐			
Cancer History Description	**Check**	**YOURSELF or Relatives (see list above)**	**Paternal/Maternal**	**Age(s) of Diagnosis**
Colon cancer before the age of **50**	Yes ☐ No ☐			
Uterine/Endometrial cancer before the age of **50**	Yes ☐ No ☐			
Three or more Lynch cancers. Lynch cancers are: colon, endometrial, gastric, ovarian, brain, pancreatic, small bowel, hepatobiliary tract, ureter/renal, or sebaceous adenomas	Yes ☐ No ☐			
Breast cancer diagnosed at or before the age of **50**	Yes ☐ No ☐			
Ovarian cancer diagnosed at **any age**	Yes ☐ No ☐			
Male breast cancer diagnosed at **any age**	Yes ☐ No ☐			
Three or more breast cancers on the same side of the family regardless of age	Yes ☐ No ☐			

A relative diagnosed with breast cancer **twice**	Yes ☐ No ☐			
You are of Ashkenazi Jewish heritage and have a diagnosis of breast, or pancreatic cancers in any family members listed above at any age	Yes ☐ No ☐			
Have any of your family members been tested for the BRCA gene? If no, why not?	Yes ☐ No ☐			
If you don't have any known history of cancer in your family, check here ☐				
Please list ANY other cancers, along with which relative, and side of the family:				

OFFICE USE ONLY		
Appropriate for testing? Yes ☐ No ☐	Discuss Genetic Testing? Yes ☐ No ☐	Genetic Testing: Accepted ☐ Denied ☐
MD Signature: _____	If declined, state reason: _____	
If declined, patient signature: _____	Written information given: Yes ☐ No ☐	