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 ☐
Occupation:		With: Men ☐ Women ☐ Both ☐
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 Diseases 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						**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 SURGICAL HISTORY
List ANY 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 and Paternal Grandparents, Great Aunts/Uncles

Name: _____ Doctor: _____ Date: _____

FAMILY HISTORY				
Disease Type	**Check**	**List All Relatives (see list above)**		**Paternal/ Maternal**
Heart Attack	Y ☐ N ☐			
Stroke	Y ☐ N ☐			
Blood Clots (other than stroke)	Y ☐ N ☐			
Diabetes	Y ☐ N ☐			
Depression	Y ☐ N ☐			
Osteoporosis	Y ☐ N ☐			
Cancer History Description	**Check**	**YOURSELF or Relatives (see list above)**	**Paternal/ Maternal**	**Age(s) of Diagnosis**
Colon cancer before the age of **50**	Y ☐ N ☐			
Uterine/Endometrial cancer before the age of **50**	Y ☐ N ☐			
Three or more Lynch cancers, Lynch cancers are: colon, endometrial, gastric, ovarian, brain, pancreatic, small bowel, hepatobiliary tract, ureter/renal, or sebaceous adenomas	Y ☐ N ☐			
Breast cancer diagnosed at or before the age of **50**	Y ☐ N ☐			
Ovarian cancer diagnosed at **any age**	Y ☐ N ☐			
Male breast cancer diagnosed at **any age**	Y ☐ N ☐			
Three or more breast cancers on the same side of the family regardless of age	Y ☐ N ☐			
A relative diagnosed with breast cancer **twice**	Y ☐ N ☐			
You are of **Ashkenazi Jewish** heritage and have a diagnosis of breast, or pancreatic cancers in any family members listed above at any age	Y ☐ N ☐			
Have you or any of your family members been tested for the BRCA gene? If no, why not?	Y ☐ N ☐			
If you don't have any known history of cancer in your family check here ☐				
Please list ANY other cancers, along with what relative, and side of 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 ☐