Sonoran Medical Centers
Gynecology Patient Health History
Jacqueline Belen, DO

Patient Name:_____ Date:_____
Date of Birth: _____ (please answer all that are applicable)
Who is your primary doctor (PCP)? _____
What age did you start your first period?_____ Are you still having periods (Pre-menopausal)?_____
First day of Last Monthly Period? _____ How many days do your periods last? _____
How many days are there between the first day of your period to the first day of your next period?_____
What's the flow like for your periods? Normal?_____Heavy?_____Light?_____Spotting?_____
Do you have any out of the ordinary pain with menses (Dysmenorrhea)? _____
Have you ever taken birth control pills? _____ How many years? _____
How many pregnancies? ____ Live births? ____ Miscarriages? ____ Abortions? ____
Any family history of cervical cancer? _____Who? _____
What age did you stop having your periods?_____
Was menopause natural? _____ If not, why?_____
Are you taking hormone replacement therapy? _____Medication name: _____
Have you ever taken hormone replacement therapy? Y N How many years total? _____
Have you had any bleeding with hormone replacement therapy? _____
Have you had any problems with hormone replacement therapy? _____

	Yes	No
Do you have any nipple discharge?		
Do you have any breast lumps?		
Do you have any breast pain?		
Have all your mammograms been normal in the past? If not, what was found? _____		
Do you perform monthly self breast exams?		
Have you had a tubal ligation (tubes tied)?		
Has your partner had a vasectomy?		
Do you use an IUD? What type is it and when was it placed? _____ Year___		
Are you sexually active with a male?		
Are you sexually active with a female?		
Have you had a new partner within the last six months?		
Do you have a history of a sexually transmitted disease?		
Do you have any vaginal odor?		
Do you have any vaginal itching?		
Do you have any vaginal discharge?		
Do you have any pelvic pain?		
If you do, does your pelvic pain cycle with your menses?		
Do you have any bleeding after intercourse?		

Have all your pap smears been normal in the past? If not, what abnormality was found? _____		
If you do not have an IUD or tubal ligation and if you are sexually active with a male partner, what type of birth control do you currently use? _____		

Do you have a history of:	Yes	No	Date
Infertility?			
Sexual dysfunction?			
Pain with intercourse?			
Fibroids?			
Ovarian Cysts?			
Have **you** personally been diagnosed with any of the following:			
Hepatitis/ Liver Disease			
Colitis/ Irritable Bowel			
Osteopenia/ Osteoporosis			
Polycystic Ovarian Syndrome			
Endometriosis			
Breast Cancer			
Uterine Cancer			
Cervical Cancer			
Sexual Abuse			
HIV			

Provider_____ MA_____ Front_____ Date _____

SONORAN MEDICAL CENTERS NEW PATIENT HEALTH HISTORY

Date_____ Date of Birth: _____
Name:_____
Name you prefer to be called:_____
Race: □American Indian or Alaska Native □Asian □Black or African American □Native Hawaiian or Other Pacific Islander □White
Ethnicity: □Hispanic or Latino □Not Hispanic or Latino
Preferred Language:_____

Pharmacy Name: _____
Pharmacy Cross Streets_____
Pharmacy Phone Number (_____)_____
Mail Order Pharmacy Name: _____
Mail Order ID # _____

Allergies to Medications:	**Reaction:**

Chronic Medical Problems:	**Year diagnosed:**

When was your last:	**Result:**	**Date:**
Physical Exam		
Colonoscopy		
Glaucoma check		
Bone Density (DEXA)		
Mammogram (females)		
Abnormal Mammogram		
Pap Smear (females)		
Abnormal Pap Smear		

When was your last:	**Date:**
Influenza Vaccine (Flu)	
Pneumonia Vaccine	
Tetanus Vaccine □ with Pertussis?	
Hepatitis A Vaccine	
Hepatitis B Vaccine	
HPV? (3 shots)	
Zoster (Shingles) Vaccine (over 60)	
Have you had the chicken pox?	

Do you have allergies? Yes No

Religious Affiliation (optional)
Do you have a religious affiliation?
_____
Do you practice your religion? Yes No

List Past Surgeries:	**Year:**
Any blood transfusions?	

List Past Hospitalizations:	**Year:**

Family History: (blood relatives only)	**Relationship:**	**Was cause of death?**
Heart Disease		
Cancer Breast		
Cancer Colon		
Cancer of Lung		
Cancer of Ovaries		
Cancer of Prostate		
Cancer of Uterus		
Stroke		
Depression		
Diabetes		
High Cholesterol or Triglycerides		
High Blood Pressure		
Thyroid Disease		
Other		

Social History: Marital Status: (S,M,D,W):_____
Occupation:_____
# of Children: Sons_____Daughters_____
Who do you live with?_____

Tobacco?	**Type?**	**How much?**	**How long?**
Current			
Past			
Alcohol?			
Caffeine?			
Illegal Drugs?			
IV Drugs?			

If past smoker, what age did you quit?_____
Activity level: low_____average_____high_____
Do you have a DNR (do not resuscitate)?_____
Do you have a living will?_____
Do you have a power of attorney? _____
Do you have a health care proxy?_____
Any tattoos?_____
If you are a patient of Dr. Belen, please complete Gyn Patient Health History also.

Sonoran Medical Centers

Patient Medication, Vitamin and Supplement Log

for (name) _____ DOB: _____ Today's Date: _____

Include prescription medications, over-the-counter medications, vitamins and herbal supplements

Pharmacy Name: _____ Phone: _____ Pharmacy Cross Streets: _____

Mail Order Pharmacy Name: _____ Mail Order ID #: _____

Start Date	Name of Medicine Brand Name/Generic Name	Dose (mg, units)	# taken per day	When do you take it? Morning/night, after meals	With food? Y or N	What's it for? Purpose	Size/color/ shape	Prescribed by Provider's name	Local Pharm or Mail order	Important Comments (danger signs, side effects, interactions)

Please bring this updated form with you to all of your medical office visits. If your medicines change, please tell your medical provider.
Check the detailed drug sheets provided by the pharmacy with each medication, or talk to your doctor about possible side effects, danger signs and interactions.

Allergies to: _____

Other Medical Providers that you are seeing (please include dentist and eye doctor):

Last Seen	Provider name	Specialty	Problem they are treating	Comments

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19875 N. 51st Avenue
Glendale, AZ 85308
Phone: (623) 581-8998
Fax: (623) 581-6461

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient's Name: _____Date of Birth: _____
Phone:_____ Address: _____
City:_____State:_____Zip Code: _____

I hereby authorize
Name of facility:_____
Address:_____City:_____
State:_____ Zip Code:_____Phone:_____Fax:_____
to disclose the following Protected Health Information pertaining to the patient listed above to Sonoran Medical Centers.

Options below must be completed in order to release records.

For the Following Purpose:
☐ New Primary Care Physician
☐ Personal Records
☐ Consultation with Specialist
☐ Insurance Company
☐ Other (Specify) _____
☐ Other (Specify) _____

Information to be Released:
☐ All Records
☐ Records from _____ to_____
☐ Office Note
☐ Radiology Report ☐ Lab result
☐ Billing Statements

I understand this authorization covers records relating to communicable diseases, acquired immunodeficiency syndrome ("AIDS'), human immunodeficiency virus ('HIV"), behavioral and/or mental health care, alcohol and/or drug abuse treatment, and genetic testing, if any such records exist.
I understand that Sonoran Medical Centers will not condition treatment on whether I sign this Authorization.
I understand that I have the right to revoke this authorization at any time except to the extent that the above-named facility has already taken action in reliance on it. I understand that in order to revoke this authorization, I must do so in writing and present my written revocation to the mailing address listed above. I understand the revocation will not apply to information that has already been released in response to this Authorization.
I understand that, if this information is disclosed to a third party, the information may no longer be protected by federal privacy regulations and may be redisclosed by the person or entity that receives this information.

I understand that this authorization will expire one (1) year from date of signing unless specified below.

Desired Expiration Date _____

_____ _____
Signature **Date**

_____ _____
Print Name **Relationship to Patient (if not patient)**

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							
☐ 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*						

☐ 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)

Your PERSONAL History – Red Flags

Hereditary Breast and Ovarian Cancer Syndrome

- ☐ Breast cancer diagnosed at age 50 or younger
- ☐ Ovarian cancer at any age
- ☐ Two primary occurrences of breast cancer
- ☐ Male breast cancer
- ☐ Triple Negative Breast Cancer
- ☐ Pancreatic cancer with a breast or ovarian cancer
- ☐ Ashkenazi Jewish ancestry with an HBOC-associated cancer*

Lynch Syndrome* *(see cancer list below)*

- ☐ Colorectal cancer under age 50
- ☐ Endometrial/uterine cancer under age 50
- ☐ MSI High histology*** before age 60
- ☐ Abnormal MSI/IHC tumor test result *(colon/rectal/endometrial/uterine)*
- ☐ Two or more Lynch syndrome cancers** at any age
- ☐ YOU and one or more relatives with a Lynch syndrome cancer**

Your FAMILY History – Red Flags

Hereditary Breast and Ovarian Cancer Syndrome

- ☐ Close relative with breast cancer less than age 50
- ☐ Close relative with ovarian cancer at any age
- ☐ Two or more breast cancer occurrences, in one relative or in two or more relatives on the same side of the family, one under age 50
- ☐ A male relative with breast cancer
- ☐ Combination of breast, ovarian, and/or pancreatic cancer on the same side of the family.
- ☐ Three or more relatives with breast cancer at any age
- ☐ A previously identified *BRCA1* or *BRCA2* mutation in the family

Lynch Syndrome* *(see cancer list below)*

- ☐ 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 mutation in the family

*HBOC associated cancer includes: *Breast, ovarian, and pancreatic cancer*

**Lynch syndrome cancer includes: *Colon, endometrial/uterine, gastric/stomach, ovarian, ureter/renal pelvis, biliary tract, small bowel, pancreas, brain and sebaceous adenomas*

***MSI High histology includes: *Mucinous, signet ring, tumor infiltrating lymphocytes, crohn's-like lymphocytic reaction histology, or medullary growth pattern*

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:_____