SONORAN MEDICAL CENTERS NEW PATIENT HEALTH HISTORY

Date_____ Date of Birth: _____
Name: _____
Name you prefer to be called: _____
Preferred Language: _____

Pharmacy Name: _____
Pharmacy Cross Streets: _____
Pharmacy Phone Number (_____)_____
Mail Order Pharmacy Name: _____

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 (Gardasil) (2-3 shots)	
Zoster (Shingles) Vaccine (over 50)	
Have you had the chicken pox?	

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

List Past Hospitalizations:	**Year:**

Family History: (blood relatives only)	**Was cause of death?**	**Relationship to you?**
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? _____

	How much?	**How often? (day/wk/mo)**	**Age Start - Stop**
Cigarette?			-
Cigarette- If restarted			-
Cigar?			-
Chew?			-
Pipe?			-
Vape?			-
Marijuana?			-
Alcohol? **Type:**			-
Caffeine?			-
Illegal Drugs?			-
Other?			-

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?_____

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

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			

Myriad Myrisk Cancer Family Health Questionnaire

Personal Information			
Patient Name	Date of Birth	Healthcare Provider Jacqueline Belen DO	Today's Date

Instructions: Your personal and family history of cancer is important to provide you with the best care possible. Please complete the chart below based upon your personal and family history of cancer. Leave blank what you do not know. The following relatives should be considered: Parents, siblings, half-siblings, children, grandparents, grandchildren, aunts, uncles, nieces and nephews on both sides of the family.

Do you have a personal history of:	Yes (Y) or No (N)?	Which cancer?	Age at diagnosis?
Breast, ovarian, or pancreatic cancer at any age	☐ Y ☐ N		
Colorectal or uterine cancer at 64 or younger	☐ Y ☐ N		

Do you have a family history of:	Yes (Y) or No (N)?	Which relative?	Maternal (M) or Paternal (P) side of the family?	Age at diagnosis?
Breast cancer at 49 or younger	☐ Y ☐ N		☐ M ☐ P	
Two breast cancers (bilateral) in one relative at any age	☐ Y ☐ N		☐ M ☐ P	
Three breast cancers in relatives on the same side of the family at any age	☐ Y ☐ N		☐ M ☐ P	
Ovarian cancer at any age	☐ Y ☐ N		☐ M ☐ P	
Pancreatic cancer at any age	☐ Y ☐ N		☐ M ☐ P	
Male breast cancer at any age	☐ Y ☐ N		☐ M ☐ P	
Metastatic prostate caner at any age	☐ Y ☐ N		☐ M ☐ P	
Colon cancer at at 49 or younger (1st degree relative)	☐ Y ☐ N		☐ M ☐ P	
Uterine Cancer at 49 or younger (1st degree relative)	☐ Y ☐ N		☐ M ☐ P	
Ashkenazi Jewish ancestry with breast cancer at any age	☐ Y ☐ N		☐ M ☐ P	
If you have a family history of any other cancers, list them here:				
Have you or anyone in your family had genetic testing for hereditary cancer?	☐ Y ☐ N	Who?	What gene(s)?	What was the result?

Cancer Risk Assessment Review

Patient Signature_____ Date_____

Healthcare Provider Signature_____ Date_____

Office use only Patient offered herediary cancer genetic testing? ☐ Y ☐ N

If yes, which test? _____

Follow-up apointment scheduled? ☐ Y ☐ N Date of next appointment? _____

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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
☐ FMLA/Disability
☐ Other (Specify) _____
☐ Other (Specify) _____

Information to be Released:
☐ All Records
☐ Records from _____ to_____
☐ Office Note
☐ Radiology Report ☐ Lab result
☐ Other
☐ Billing Statements
☐ FMLA/Disability Forms (please mark above if records to be released also)

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)**