SARATOGA OB/GYN
AT MYRTLE STREET
A SERVICE OF SARATOGA REGIONAL MEDICAL, P.C.
AN AFFILIATE OF SARATOGA HOSPITAL

PATIENT NAME: _____ **DATE OF BIRTH:** _____

TODAY'S DATE: _____ **REASON FOR YOUR VISIT:** _____

The following questions cover important gynecologic issues for all women. We strongly encourage everyone to have a primary care provider to cover other health issues.

GENERAL GYN HEALTH

Premenopausal	Postmenopausal/ Hysterectomy
Date of last menstrual period: _____	Vaginal bleeding ☐ Yes ☐ No
Any problems with your periods? _____	Any Postmenopausal symptoms?
What is your current birth control? _____	☐ Hot flashes or night sweats
Do you want to change your birth control? ☐ Yes ☐ No	☐ Difficulty Sleeping
Are you planning to get pregnant in the next 12 months? ☐ Yes ☐ No	☐ Vaginal Dryness
Have you been trying for pregnancy for more than 12 months? ☐ Yes ☐ No	Would you like to discuss therapy for above symptoms? ☐ Yes ☐ No

SEXUALITY

Have you ever been sexually active? ☐ Yes ☐ No

Are you currently sexually active? ☐ Yes ☐ No If yes, Is your sexual partner ☐ Male ☐ Female ☐ Other_____

Any problems with intercourse? ☐ Yes ☐ No _____

Would you like to be tested for sexually transmitted diseases? ☐ Yes ☐ No

Are you with the same partner as last year? ☐ Yes ☐ No If no, how may partners have you had this past year? _____

Do you feel safe at home ? ☐ Yes ☐ No If no, please explain_____

_____

Has anyone hurt you this past year ☐ Yes ☐ No If yes, please explain_____

_____

INTERVAL HISTORY

In the last year, have you been diagnosed with any new medical conditions? _____

_____

In the last year, have you had any surgeries?_____

_____

Have you had any tests this past year? (i.e. Colonoscopy)

_____

ANY NEW FAMILY HISTORY?

☐ Breast cancer: Relationship/age of onset_____

☐ Ovarian cancer: Relationship/age of onset_____

☐ Endometrial cancer: Relationship/age of onset_____

☐ Colon cancer: Relationship/age of onset_____

☐ Other: Relationship/age of onset_____

GENERAL HEALTH

Do you smoke Cigarettes, E-Cigarettes, or other tobacco products? ☐ Yes ☐ No

If yes, how much do you smoke daily? _____If yes would you like to quit? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No If yes, ☐ Less than 8 drinks per week ☐ More than 8 drinks per week: _____

Do you use drugs? ☐ Yes ☐ No If yes, type and frequency: _____

Do you exercise? ☐ Yes ☐ No If yes, type: _____

How many times per week: _____ Duration: _____minutes

Do you have an eating disorder or appetite changes? ☐ Yes ☐ No If yes, please describe: _____

Are you currently employed? ☐ Yes ☐ No If yes, Occupation: _____

What is your current marital status? ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Other: _____

DO YOU CURRENTLY HAVE ANY OF THE SYMPTOMS?

General: ☐ Extreme Fatigue ☐ Depression ☐ Anxiety ☐ Weight Change ☐ Heat/Cold intolerance

Skin: ☐ New or change in mole ☐ Rash

Cardiovascular/Respiratory: ☐ Chest Pain ☐ Palpitations ☐ Shortness of Breath ☐ Cough

Breast: ☐ Lump ☐ Nipple Discharge ☐ Redness

Gastrointestinal: ☐ Abdominal pain ☐ Bloating ☐ Change in bowel movements ☐ Nausea/vomiting

☐ Constipation ☐ Diarrhea

Gynecologic: ☐ Abnormal Vaginal discharge ☐ Pain with Intercourse ☐ PMS Symptoms ☐ Pelvic pain

Urinary: ☐ Loss of urine ☐ Blood in urine ☐ Pain with urination ☐ Urinary urgency and frequency

Neurological: ☐ Change in headaches

Are there any issues you would like to discuss today?

_____

_____

_____

Thank you for trusting us with your care

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Patient Health Questionnaire (PHQ-9)

Patient Name: _____ **Date:** _____

	Not at all	Several days	More than half the days	Nearly every day
1. Over the *last 2 weeks*, how often have you been bothered by any of the following problems?				
a. Little interest or pleasure in doing things	☐	☐	☐	☐
b. Feeling down, depressed, or hopeless	☐	☐	☐	☐
c. Trouble falling/staying asleep, sleeping too much	☐	☐	☐	☐
d. Feeling tired or having little energy	☐	☐	☐	☐
e. Poor appetite or overeating	☐	☐	☐	☐
f. Feeling bad about yourself or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
g. Trouble concentrating on things, such as reading the newspaper or watching television.	☐	☐	☐	☐
h. Moving or speaking so slowly that other people could have noticed. Or the opposite; being so fidgety or restless that you have been moving around a lot more than usual.	☐	☐	☐	☐
i. Thoughts that you would be better off dead or of hurting yourself in some way.	☐	☐	☐	☐
2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
	☐	☐	☐	☐