TODAY'S DATE: _____

## Haugen OB/GYN Established Patient Medical History

PATIENT NAME: _____ DATE OF BIRTH: _____

PRIMARY CARE PHYSICIAN: _____ PHARMACY NAME & CITY _____

Issues you want to discuss with your Provider today: _____

**Menstrual History:** (Skip to next section if menopausal)
First day of last period: _____
____regular or ____irregular
How many days apart? _____
Flow: ____light ____moderate ____heavy
# Of tampons or pads per 24 hours_____
How many days does your period last? _____
Cramps/pain ____mild ____moderate ____severe
Bleeding between periods? ____yes ____no

Birth control Method: _____

**Your age at menopause** _____
Did/do you take hormone replacement therapy?
____ yes ____ no
If yes, what and when? _____
Do you have ____hot flashes
____ night sweats
____ vaginal dryness

**Relationship Status:**
___single ___married
___dating ___divorced
___partnered ___widowed

Partner is:
____ male
____ female
____ transgender

**Are you sexually active?** ____ yes ____ no
Any problems with sexual activity? ____ yes ____ no

**Tobacco use:** ____ yes how much? _____
____ never
____ quit when? _____

**Alcohol use:** ___ yes ____ no If yes, how much? _____
Do you think you should cut down on your drinking? ____yes ____ no
Have people annoyed you by criticizing your drinking? ____yes ____no
Have you felt guilty about your drinking? ____yes ____no
Do you ever have a drink first thing in the morning? ____ yes ____ no

**Recreational Drug Use:** ____ yes ____ no

**What do you do for exercise:** _____
how often: _____

Do you feel **safe** at home and work? ____yes ____ no

**Current Occupation:** _____

Do you have a **Health Care Directive/Living Will?** ____yes ____ no
If no- would you like information on one? ____ yes ____ no

**Medications** you are regularly taking, including prescription, over the counter, herbs, dietary supplements, inhalers, topical creams. **Please include the dose.**

_____
_____
_____
_____

**Please check if you have any of the following in the past month:**

**Constitutional Symptoms:**
__fatigue
__weight loss
__weight gain
__frequent illness

**Eyes:**
__glasses/contacts
__vision changes

**Ears/nose/throat:**
__headache
__dizziness
__sore throat
__sinus congestion
__allergy symptoms

**Breasts:**
__lumps
__tenderness
__nipple discharge

**Heart:**
__chest pain
__palpitations

**Respiratory:**
__shortness of breath
__cough
__wheezing

**Gastrointestinal:**
__abdominal pain
__nausea or vomiting
__diarrhea
__constipation
__blood in stool
__incontinence of stool

**Genitourinary:**
__urinary urgency
__urinary frequency
__pain with urination
__incontinence/leaking urine
__abnormal vaginal discharge
__pelvic pain

**Skin:**
__rash
__change to existing mole/lesion

**Neurologic:**
__muscle weakness
__poor coordination
__tingling
__numbness

**Musculoskeletal:**
__joint pain
__back pain

**Endocrine:**
__excessive urination
__cold intolerance
__heat intolerance

**Psychiatric:**
__anxiety
__depression
__sleep problems
__irritability
__mood swings
__cry easily

**Hematologic:**
__easy bleeding
__easy bruising
__enlarged or tender lymph nodes

Haugen OB/GYN

# PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

| Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✓" to indicate your answer)* | Not at all | Several days | More than half the days | Nearly every day |
|---|---|---|---|---|
| 1. Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| 2. Feeling down, depressed, or hopeless | 0 | 1 | 2 | 3 |
| 3. Trouble falling or staying asleep, or sleeping too much | 0 | 1 | 2 | 3 |
| 4. Feeling tired or having little energy | 0 | 1 | 2 | 3 |
| 5. Poor appetite or overeating | 0 | 1 | 2 | 3 |
| 6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down | 0 | 1 | 2 | 3 |
| 7. Trouble concentrating on things, such as reading the newspaper or watching television | 0 | 1 | 2 | 3 |
| 8. 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 | 0 | 1 | 2 | 3 |
| 9. Thoughts that you would be better off dead or of hurting yourself in some way | 0 | 1 | 2 | 3 |

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

**If you checked off any problems, 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 |
|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ |