TODAY'S DATE: _____

Haugen OB/GYN Medicare Established Patient 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? _____

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

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:

Breasts:
__lumps
__tenderness
__nipple discharge

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
__tingling
__numbness

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
☐	☐	☐	☐