NEW PATIENT · PLEASE COMPLETE BEFORE YOUR FIRST VISIT

# Your Health History

This helps Dr. Young get to know you before your visit. Skip anything you'd rather talk about in person.

Young Gynecology · 2054 30th Ave, Fairbanks, AK 99701 · Phone 907-600-2765 · Fax 504-474-4707

## 1 About you

Full legal name _____ Name you go by _____

Date of birth _____ Pronouns (optional) _____ Today's date _____

Phone _____ Email _____

Primary care clinician _____ Preferred pharmacy _____

Country where you were born _____ Preferred language _____

Emergency contact (name, relationship) _____ Phone _____

Main reason for your visit _____

_____

## 2 Allergies

☐ No known allergies ☐ Latex allergy ☐ Iodine or contrast dye ☐ Adhesive tape

| Medicine, food or other allergy | What happened (reaction) |
|---|---|
| | |
| | |
| | |

## 3 Current medicines

Include prescriptions, hormones, birth control, inhalers, creams and over-the-counter medicines.

☐ I take no medicines

| Medicine | Dose | How often | What it's for |
|---|---|---|---|
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## 4 Vitamins, supplements and herbs

☐ I take none

| Supplement | Amount | How often |
|---|---|---|
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| | | |
| | | |
| | | |
| | | |
| | | |

Name _____ Date of birth _____

## 5 Symptoms

Check anything you've noticed in the past 3 months.

### MENOPAUSE & MIDLIFE

- ☐ Hot flashes or night sweats
- ☐ Trouble sleeping
- ☐ Mood changes, anxiety or irritability
- ☐ Brain fog or trouble focusing
- ☐ Fatigue or low energy
- ☐ Joint or muscle aches
- ☐ Weight change, especially around the belly
- ☐ Hair thinning or skin changes
- ☐ Heart racing or palpitations

### VAGINAL, BLADDER & SEXUAL HEALTH

- ☐ Vaginal dryness, burning or itching
- ☐ Pain with sex
- ☐ Low libido
- ☐ Trouble with arousal or orgasm
- ☐ Urinary urgency or frequency
- ☐ Leaking urine (coughing, laughing or urgency)
- ☐ Frequent bladder infections

### PERIODS & BLEEDING

- ☐ Heavy periods or large clots
- ☐ Irregular or unpredictable periods
- ☐ Painful periods or cramps
- ☐ Bleeding between periods
- ☐ Bleeding after sex
- ☐ Any bleeding after menopause
- ☐ Bad PMS or mood changes before periods

### PELVIC & BREAST

- ☐ Pelvic pain or pressure
- ☐ Feeling of a bulge in the vagina
- ☐ Unusual discharge or odor
- ☐ Concern about a sexually transmitted infection
- ☐ Breast lump, pain or nipple discharge

### OTHER

- ☐ Headaches or migraines
- ☐ Constipation or bowel changes
- ☐ Other: _____

## 6 Periods, pregnancy and birth control

Age at first period _____ First day of last period _____ Days between periods _____

My periods are: ☐ Regular ☐ Irregular ☐ Stopped (menopause) ☐ Stopped after surgery or ablation

If stopped, age at last period _____ Any bleeding since? ☐ No ☐ Yes

Pregnancies _____ Vaginal births _____ Cesarean births _____ Miscarriages / other _____

Pregnancy problems (e.g., preeclampsia, gestational diabetes) _____

Birth control now: ☐ None ☐ Pill, patch, ring ☐ IUD ☐ Implant ☐ Shot ☐ Condoms ☐ Tubes tied or vasectomy ☐ Other

Planning a pregnancy, or could you become pregnant, in the next year? ☐ Yes ☐ No ☐ Not sure

Sexually active: ☐ Yes ☐ No ☐ Prefer to discuss Partners: ☐ Men ☐ Women ☐ More than one gender

## 7 Screening and prevention

Approximate dates are fine.

Last well-woman exam _____ Ever tested for HIV? ☐ Yes, year _____ ☐ No ☐ Not sure

Last Pap / HPV test _____ Result _____ Ever abnormal? ☐ No ☐ Yes

If abnormal, I've had: ☐ Colposcopy ☐ LEEP or cone biopsy

Last mammogram _____ Last bone density (DEXA) scan _____

Ever told you have dense breasts? ☐ Yes ☐ No ☐ Not sure Have you fallen in the past year? ☐ Yes ☐ No

Colon cancer screening: ☐ Colonoscopy, year _____ ☐ Stool test (Cologuard or FIT), year _____ ☐ Never

Last cholesterol check _____ Last blood sugar / A1c test _____ Tested for hepatitis C? ☐ Yes ☐ No ☐ Not sure

Vaccines I have had: ☐ Flu (this season) ☐ COVID (this season) ☐ Tdap (last 10 years) ☐ HPV ☐ Shingles (Shingrix) ☐ Pneumonia ☐ RSV ☐ Hepatitis B

New sex partner in the past year? ☐ Yes ☐ No Would you like STI testing at this visit? ☐ Yes ☐ No

If you leak urine, does it limit your activities or quality of life? ☐ Yes ☐ No ☐ I don't leak

### OVER THE LAST 2 WEEKS, HOW OFTEN HAVE YOU BEEN BOTHERED BY:

| | Not at all | Several days | More than half the days | Nearly every day |
|---|---|---|---|---|
| Feeling nervous, anxious or on edge | ☐ | ☐ | ☐ | ☐ |
| Not being able to stop or control worrying | ☐ | ☐ | ☐ | ☐ |
| Little interest or pleasure in doing things | ☐ | ☐ | ☐ | ☐ |
| Feeling down, depressed or hopeless | ☐ | ☐ | ☐ | ☐ |

Would help with transportation, an interpreter or cost make it easier to get your screening tests? ☐ Yes ☐ No

Name _____ Date of birth _____

## 8 Medical history

Check any you have now or have had in the past.

- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Diabetes or prediabetes
- ☐ Diabetes during a pregnancy
- ☐ Heart disease or heart attack
- ☐ Stroke or mini-stroke (TIA)
- ☐ Blood clot in leg or lung
- ☐ Clotting or bleeding disorder
- ☐ Migraines with aura
- ☐ Migraines without aura
- ☐ Thyroid disease
- ☐ Asthma or lung disease
- ☐ Sleep apnea
- ☐ Liver disease or hepatitis
- ☐ Kidney disease
- ☐ Gallbladder disease
- ☐ Osteoporosis or osteopenia
- ☐ Anemia (low iron)
- ☐ Autoimmune disease
- ☐ Depression or anxiety
- ☐ Other mental health condition
- ☐ Breast cancer
- ☐ Other cancer: _____
- ☐ Endometriosis
- ☐ Fibroids
- ☐ Polycystic ovary syndrome (PCOS)
- ☐ Sexually transmitted infection
- ☐ Seizures

Other conditions _____

## 9 Surgeries and procedures

- ☐ Hysterectomy
- ☐ Ovaries removed: one / both
- ☐ Tubes tied or removed
- ☐ Cesarean birth
- ☐ Endometrial ablation
- ☐ D&C or hysteroscopy
- ☐ Laparoscopy
- ☐ LEEP or cone biopsy
- ☐ Breast surgery or biopsy

| Surgery or procedure (any kind) | Year | Reason |
|---|---|---|
| | | |
| | | |
| | | |

Any problems with anesthesia? ☐ No ☐ Yes: _____

## 10 Family history

Blood relatives only. Write who (e.g., mother, sister, aunt).

Breast cancer _____
Ovarian cancer _____
Uterine cancer _____
Colon cancer _____
BRCA or other cancer gene _____
Heart attack or stroke before 60 _____
Blood clots _____
Osteoporosis or hip fracture _____
Diabetes _____
Other _____

Ashkenazi (Eastern European) Jewish ancestry? ☐ Yes ☐ No ☐ Not sure

## 11 Smoking, alcohol and other substances

Do you smoke or vape? ☐ Yes ☐ No If yes, what _____ Times per week _____

Do you drink alcohol? ☐ Yes ☐ No If yes, how much per week _____

| If you drink: | Yes | No |
|---|---|---|
| Have you ever felt you should cut down on your drinking? | ☐ | ☐ |
| Have people annoyed you by criticizing your drinking? | ☐ | ☐ |
| Have you ever felt bad or guilty about your drinking? | ☐ | ☐ |
| Have you ever had a drink first thing in the morning to steady your nerves or ease a hangover? | ☐ | ☐ |

Do you use cannabis (marijuana, THC)? ☐ Yes ☐ No If yes, times per week _____

Have you ever used crack, cocaine, heroin or methamphetamine? ☐ Yes ☐ No If yes, which and when last _____

## 12 Lifestyle

Exercise (type, times per week) _____ Work _____

Do you feel safe at home and in your relationships? ☐ Yes ☐ No ☐ I'd like to talk privately

## 13 Signature

The information on this form is true and complete to the best of my knowledge.

Signature _____ Date _____