Capital Internal Medicine Associates, P.C.
CIMA

A New Beginning – Obstetrics and Gynecology
An Affiliate of Capital Internal Medicine Associates, P.C.

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Haslett, MI 48840
Phone: 517-853-5576
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111 S. Lansing St. Suite 200
Charlotte, MI 48813
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Patient Health Questionnaire

NAME: _____ **TODAY'S DATE:** _____ **BIRTHDATE:** _____

Pharmacy: _____

CURRENT MEDICATIONS AND DOSAGE:
(Include herbals or vitamins)

_____
_____
_____
_____
_____

ALLERGIES TO MEDICATIONS:
(Include type of reaction)

_____
_____
_____
_____
_____

PAST MEDICAL PROBLEMS:

_____
_____
_____
_____
_____

PAST SURGERIES (Include dates)**:**

_____
_____
_____
_____
_____

SYMPTOM REVIEW: (please circle all that apply)

GENERAL: Fever Chills Night Sweats

SKIN: Rash Itching Hives

HEAD AND NECK: Hearing Loss Bloody Nose Sore Throat Swollen Glands

RESPIRATORY: Shortness of Breath Cough

CARDIOVASCULAR: Chest Pain Irregular Heartbeat Fluid accumulation in legs

GASTROINTESTINAL: Recurrent Abdominal Cramping Vomiting Diarrhea Constipation Difficulty Swallowing Blood in Stool

GENITOURINARY: Blood in Urine Frequent Urination Painful Urination Urgency to Urinate Urinary Incontinence

GYNECOLOGICAL: Heavy Bleeding Irregular Bleeding Frequent Missed Periods Painful Intercourse Painful Periods Bleeding Between Periods Vaginal Discharge Vaginal Itching

BREAST: Breast Lump Breast Pain Nipple Discharge

MUSCLES AND JOINTS: Painful Joints Joint Stiffness Decreased Motion

ENDOCRINE: Cold Intolerance Hair Loss Hot Flashes

NEUROLOGICAL: Loss of Strength Memory Loss Seizures

PSYCHOLOGICAL: Anxiety Depression Difficulty Sleeping Mental or Physical Abuse

Continued…

SOCIAL HISTORY:

SMOKING STATUS: CURRENT FORMER NEVER
If current: How many packs per day? _____ For how many years? _____
If former: How long since quitting? _____
Are you exposed to second hand smoke? YES NO

ALCOHOL USE: YES NO Drinks per week _____
CAFFEINE USE: YES NO Cups per day _____

RECREATIONAL DRUG USE: YES NO

If Yes: MARIJUANA COCAINE HEROIN METHADONE LSD OTHER_____

SEAT BELT USE: YES NO SMOKE DETECTORS IN HOME: YES NO
VICTIM OF DOMESTIC VIOLENCE: YES NO Current Past

FAMILY HISTORY: Mother, Father, Children, Brother, Sister, Grandparents

MOTHER: LIVING OR DECEASED? AGE:_____ CAUSE OF DEATH_____
FATHER: LIVING OR DECEASED? AGE:_____ CAUSE OF DEATH_____

Please list Relative(s) of any that apply:
MOTHER'S FAMILY

BREAST CANCER:	AGE AT DIAGNOSIS:
OVARIAN CANCER:	AGE AT DIAGNOSIS:
UTERINE CANCER:	AGE AT DIAGNOSIS:
HEART DISEASE:	
HIGH BLOOD PRESSURE:	
HIGH CHOLESTEROL:	
STROKE:	
DIABETES:	
BLOOD CLOTS (DVT):	
OTHER CANCER:	
THYROID DISORDERS:	
OSTEOPOROSIS:	
MENTAL DISORDER:	
BLEEDING DISORDER:	

Please list Relative(s) of any that apply:
FATHER'S FAMILY

BREAST CANCER:	AGE AT DIAGNOSIS:
OVARIAN CANCER:	AGE AT DIAGNOSIS:
UTERINE CANCER:	AGE AT DIAGNOSIS:
HEART DISEASE:	
HIGH BLOOD PRESSURE:	
HIGH CHOLESTEROL:	
STROKE:	
DIABETES:	
BLOOD CLOTS (DVT):	
OTHER CANCER:	
THYROID DISORDERS:	
OSTEOPOROSIS:	
MENTAL DISORDER:	
BLEEDING DISORDER:	

Continued…

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Obstetrics and Gynecology History

NAME:_____TODAY'S DATE:_____BIRTHDATE:_____

Marital Status Single Married Divorced Widowed Partner Separated

Occupation _____

Last Pap Smear_____

History of Abnormal Pap Smear?_____ **If yes, what was result**_____

Last Mammogram_____ **Do you perform monthly Breast exams?** Yes No

Last Bone Density_____

Last Colonoscopy_____

Last Cholesterol Test_____

Still having periods? Yes No **If no,** age menopause began_____

First day of last menstrual period_____ **Age of first period?**_____

Periods come every_____ days **Periods last how many days?**_____

Periods are Light Moderate Heavy Painful Irregular

Do you bleed between periods? Yes No

Are you Sexually Active? Yes No **Do you bleed after sex?** Yes No

Currently on Birth Control? Yes No

If yes, what type? _____ **If IUD or Nexplanon, what is insertion date?** _____

History of chronic yeast or bacterial infections? If Yes, which_____

History of STD? Chlamydia Gonorrhea Trichomoniasis Herpes Genital Warts HIV Syphilis

History of PID? Yes No

Exposure to Diethylstilbestrol (DES)? Yes No

Human Papillomavirus (HPV) vaccines? Yes No

Have you ever been Pregnant? Yes No

Number of pregnancies_____ **Number of Live Births** _____**Number of Living Children**_____

Number of Miscarriages_____ **Number of Elective Terminations**_____

Number of C-Section Deliveries _____ **Number of Vaginal Births**_____

Number of Premature Births <37 wks_____

Continued…

Risk Assessment for Lynch Syndrome and Hereditary Breast and Ovarian Cancer Syndrome

Patient Name: _____ Physician Name: _____

Date of Birth: _____ Today's Date: _____

Instructions: This is a screening tool for the common features of hereditary cancer syndromes. If you circle Y (yes) for any statement below, you may be appropriate for hereditary cancer testing. When you circle Y, please provide the family member's relationship to you, the site of their cancer and their age when they were diagnosed with cancer.

Mother/Father/Sister/Brother/Children = **1st Degree Relatives**

Aunt/Uncle/Grandparent/Niece/Nephew = **2nd Degree Relatives** Cousin/Great Grandparent = **3rd Degree Relatives**

Have you or any of your relatives been tested for hereditary cancer (HBOC/BRACAnalysis or Lynch/COLARIS)? YES NO

Have you ever been diagnosed with cancer? What site: _____ What age: _____

		COLON AND UTERINE CANCER (COLARIS)	SELF	FAMILY MEMBER		AGE AT DIAGNOSIS
				MOTHER'S SIDE	FATHER'S SIDE	
Y	N	**THREE (3)** relatives on the same side of the family with Uterine (Endometrial) and/or Colorectal cancer at any age				
Y	N	**TWO (2)** relatives on the same side of the family with Uterine (Endometrial) and/or Colorectal cancer under age 50				
Y	N	**ONE (1)** Uterine (Endometrial) and/or Colorectal cancer under age 50 in self				
Y	N	A family member with a known Lynch Syndrome mutation				

		BREAST AND OVARIAN CANCER (BRACAnalysis)	SELF	FAMILY MEMBER		AGE AT DIAGNOSIS
				MOTHER'S SIDE	FATHER'S SIDE	
Y	N	**ONE (1)** Breast cancer at age 45 or younger (in self, first or second degree family members)				
Y	N	**ONE (1)** Ovarian cancer at any age (in self, first or second degree family members)				
Y	N	**TWO (2)** relatives on the same side of the family with breast cancer, one of whom was diagnosed at age 50 or younger (in self, first or second degree)				
Y	N	**THREE (3)** relatives on the same side of the family with breast and/or ovarian cancer at any age				
Y	N	**ONE (1)** Triple negative breast cancer age 60 or younger - receptor status negative for ER, PR and HER2 (in self, 1st or 2nd degree family members)				
Y	N	**ONE (1)** Male breast cancer at any age (in self, first or second degree family members)				
Y	N	**ONE (1)** Breast or ovarian cancer in Ashkenazi Jewish family members				
Y	N	**ONE (1)** Pancreatic cancer with **2** or more breast and/or ovarian cancers on the same side of the family				
Y	N	A family member with a known BRCA mutation				

Are you of Jewish descent? YES NO

Is there any other cancer in you or any family members not listed above? If yes, please provide the family member's relationship to you, the site of their cancer and their age when they were diagnosed with cancer:

_____

Patient's signature: _____ **Today's Date:** _____

FOR OFFICE USE ONLY

- ☐ Patient does not meet criteria for further risk assessment and/or genetic testing
- ☐ Patient is appropriate for further risk assessment and/or genetic testing
- ☐ Information given to patient to review
- ☐ Follow-up appointment scheduled on _____
- ☐ Patient offered genetic testing: Accepted OR Declined HCP Signature: _____