

1. Name: \_\_\_\_\_ Age: \_\_\_\_\_ D.O.B.:  
\_\_\_\_\_

2. Marital Status: Married / Single / Divorced / Widow:  
\_\_\_\_\_

Occupation: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

Referring Physician or Other: \_\_\_\_\_

3. Total # of Pregnancies \_\_\_\_\_ # full term \_\_\_\_\_ # premature \_\_\_\_\_ # of abortions \_\_\_\_\_

# of miscarriages \_\_\_\_\_ # living children \_\_\_\_\_ # vaginal deliveries \_\_\_\_\_ # of c-sections \_\_\_\_\_

4. Are you are still having periods, **(yes / no)**, if yes, complete #'s 5-8, otherwise go to # 9.

5. Age at which you began having periods? \_\_\_\_\_ Date of your last menstrual cycle  
\_\_\_\_\_

6. How many days from beginning of one period to beginning of next **(not on the pill)**  
\_\_\_\_\_

If cycle lengths are irregular, mark the shortest to the longest # of days (i.e. 21-35)

7. How many days do your period last **(not on the pill)**? \_\_\_\_\_

8. Sexually active  Yes  No

9. What method, if any, of birth control do you use?  
\_\_\_\_\_

10. Are you and your spouse / significant other planning any future pregnancies?  Yes  No  Unsure

11. Date of your last pap smear \_\_\_\_\_ Normal  Yes  No

If No, please explain: \_\_\_\_\_

12. Date of your last mammogram \_\_\_\_\_ Normal  Yes  No  
Where \_\_\_\_\_

If No, please explain: \_\_\_\_\_

Have you had a Bone Density  Yes  No Date \_\_\_\_\_ Normal  Yes  No \_\_\_\_\_

13. Medicine Allergies and type of reaction: \_\_\_\_\_ (there is a page supplied for this in your packet).

14. Medicines and Supplements you are currently taking; \_\_\_\_\_ (there is a page supplied for this in your packet).

15. If you take calcium: Brand \_\_\_\_\_ Amount: \_\_\_\_\_ mg / \_\_\_\_\_ times a day

If you take a Multivitamin: Brand \_\_\_\_\_

16. Cervical Cancer Vaccine (HPV) would you like to receive this? Check One  Yes  No  Not Sure

17. Smoke:  Yes  No Drink:  Yes  No  Occasionally Street Drugs:  Yes  No

18. Present problem ( if other than routine visit) \_\_\_\_\_

Name: \_\_\_\_\_ D.O.B.: \_\_\_\_\_

19. GYN past history (  ) and please explain below if necessary:

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> Abnormal Pap          | <input type="checkbox"/> Laser                    | <input type="checkbox"/> Sexual Abuse                             | <input type="checkbox"/> Ovarian Cysts         |
| <input type="checkbox"/> Infections; discharge | <input type="checkbox"/> Leep                     | <input type="checkbox"/> Sexual Problems                          | <input type="checkbox"/> Ovarian Cancer        |
| <input type="checkbox"/> Genital Warts         | <input type="checkbox"/> Heavy Periods            | <input type="checkbox"/> IUD / <input type="checkbox"/> B.C. Pill | <input type="checkbox"/> Uterine Cancer        |
| <input type="checkbox"/> Gonorrhhea            | <input type="checkbox"/> Painful Periods          | <input type="checkbox"/> Endometriosis                            | <input type="checkbox"/> Uterine Fibroids      |
| <input type="checkbox"/> Chlamydia             | <input type="checkbox"/> Bleeding between Periods | <input type="checkbox"/> DES                                      | <input type="checkbox"/> Pelvic Pain           |
| <input type="checkbox"/> Herpes                | <input type="checkbox"/> Absence of Periods       | <input type="checkbox"/> Breast Cysts / Lump                      | <input type="checkbox"/> Pelvic Organ Prolapse |
| <input type="checkbox"/> Colposcopy            | <input type="checkbox"/> Infertility              | <input type="checkbox"/> Biopsied                                 | <input type="checkbox"/> i.e.: bladder, uterus |
| <input type="checkbox"/> Cryo Surgery          | <input type="checkbox"/> Painful Intercourse      | <input type="checkbox"/> Nipple Discharge                         | <input type="checkbox"/> Frequent Urination    |
| <input type="checkbox"/> Other _____           |   |   | <input type="checkbox"/> Urinary Leakage       |

20. Medical Problems (  ) and circle, if necessary. Explain below if necessary.

- |   |  |
|---|--|
| <input type="checkbox"/> Constitutional (fever, weight loss, etc.)  | <input type="checkbox"/> Skin (rashes, ulcers, lesions)  |
| <input type="checkbox"/> Neurologic (migraines, epilepsy, seizures)   | <input type="checkbox"/> Breasts: Cysts: aspirated or removed                                      |
| <input type="checkbox"/> Psychiatric (depression, anxiety anorexia, bulimia, eating disorder)                                   | <input type="checkbox"/> Lumps: biopsied or removed  |
| <input type="checkbox"/> Hematologic / Lymphatic (blood clots, phlebitis, varicose veins, easy bruising, lymph nodes, leukemia) | <input type="checkbox"/> Cancer, Explain under surgery #17   |
| <input type="checkbox"/> Head, Eyes, Ears, Nose, Throat   | <input type="checkbox"/> Cardiovascular (high b.p., heart murmur, stroke, cholesterol)             |
| <input type="checkbox"/> Endocrine (Thyroid, Diabetes, Lupus)   | <input type="checkbox"/> Respiratory (lungs, asthma)   |
| <input type="checkbox"/> Muscular-Skeletal (Osteoporosis, Bone Fractures, Arthritis)  | <input type="checkbox"/> G.I. (stomach, bowel, colitis, crohn's, diverticulitis, liver, hepatitis) |
| <input type="checkbox"/> Other, explain below   | <input type="checkbox"/> G.U. (bladder, kidneys, infections)                                       |

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21. Surgeries & Dates / Years (include colonoscopies)

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22. Family History- Note which relatives that have any of the following:

High Blood Pressure: _____	Endometriosis: _____	Alzheimer's: _____
Diabetes: _____	Osteoporosis: _____	Premature Menopause: _____
Heart: _____	Thyroid: _____	Twins: _____
Cholesterol: _____	Kidney: _____	Birth Defects: _____
Cancer: _____	Other: _____	

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\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Nurse / MD Signature

\_\_\_\_\_  
Date

Candidate? Y \_\_\_ N \_\_\_

# Family History Questionnaire

Name: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_ Date \_\_\_\_\_  
 Completed: \_\_\_\_\_

Are you of Ashkenazi (Eastern or Central European) Jewish descent? Yes \_\_\_ No \_\_\_ Date of Birth: \_\_\_\_\_

Please place a check mark (✓) in the boxes below for yourself and each family member who has had the following. Include age of diagnosis.

	Breast Cancer	Ovarian Cancer	Pancreatic Cancer	Multiple Cancers in the same individual	Colon or Rectal Cancer	Colon Polyps How many?	Endometrial Cancer	Other Cancers (e.g., stomach, kidney/urinary tract, brain, small bowel, thyroid, melanoma)
Yourself								
Mother								
Father								
Sisters #__								
Brothers #__								
Daughters #__								
Sons #__								
Mother's side								
Grandmother								
Grandfather								
Aunt(s)#__								
Uncle(s)#__								
Cousin(s)#__								
Father's side								
Grandmother								
Grandfather								
Aunt(s) #__								
Uncle(s) #__								
Cousin(s) #__								

Additional Comments: \_\_\_\_\_

**Below for Office Use Only**

JCH  Patient ACCEPTS Counseling  BRACA / LYN  Physician Signature \_\_\_\_\_ Date \_\_\_\_\_



# MEDICATION LIST

NAME: \_\_\_\_\_

DOB: \_\_\_\_\_

PREFERRED PHARMACY: \_\_\_\_\_

LOCATION: \_\_\_\_\_

PHONE # \_\_\_\_\_

Medication Name	Doctor's Name	Reason for taking medication	Dosage	How often?
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## ALLERGIES TO MEDICATION

Medication Name

Allergic Reaction

SHANE M. SOPP, M.D., F.A.C.O.G.  
KATHLEEN GOFF, F.N.P.  
GYNECOLOGY

**PATIENT AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION**

I hereby authorize the use or disclosure of my identifiable health information to the **family members/caregivers** (i.e. spouse, child, parent) listed below. I understand that this authorization is voluntary. I understand that if my information is used or disclosed, the information may no longer be protected by the privacy regulations issued by the federal government.

Patient Name: \_\_\_\_\_

Social Security #: \_\_\_\_\_

**Family member(s)/caregiver(s) authorized to obtain/disclose your health information:**

Name of family member/caregiver: \_\_\_\_\_

Address \_\_\_\_\_

Phone # \_\_\_\_\_

Relationship to you: \_\_\_\_\_

Name of family member/caregiver: \_\_\_\_\_

Address \_\_\_\_\_

Phone # \_\_\_\_\_

Relationship to you: \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

SHANE M. SOPP, M.D., F.A.C.O.G.  
KATHLEEN GOFF, F.N.P.  
GYNECOLOGY \* FEMALE UROLOGY  
4900 Broad Road, P.O.B. North, Suite 2V  
Syracuse, NY 13215  
PH. (315)492-5005, FAX (315)492-5324

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

PATIENT NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

By signing this form, I hereby authorize Shane Sopp, MD/Kathleen Goff, FNP to:

receive from: \_\_\_\_\_ OR \_\_\_\_\_ disclose to: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

the health information described below (Check all that apply):

All health information

Health information relating to the following treatment or condition: \_\_\_\_\_  
\_\_\_\_\_

Other specific description: \_\_\_\_\_

Reason for this authorization: At my request

Other \_\_\_\_\_

I understand that I may refuse to sign this authorization. Treatment, payment, enrollment in a health plan or eligibility for benefits will not be conditioned on signing an authorization if to do so would be prohibited by federal or state law. I understand an authorization may be required to participate in research or where health care services are provided solely for the purpose of creating health information for a third party, and that if I refuse to sign an authorization those services may be denied.

I may revoke this authorization in writing. If I do, it will not affect any previous actions already taken in reliance upon my authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. I may revoke this authorization by writing a letter and mailing it by certified mail, return receipt requested, to the Privacy Officer at the health care provider listed above.

Once health information is disclosed pursuant to this authorization, it may be re-disclosed and may no longer be protected by privacy laws.

\_\_\_\_\_  
Patient/Legally Authorized Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Relationship to Patient

NOTE: This document must be made part of the patient's medical record. A copy of this document must be given to the patient or legally authorized representative.