

1. **Name:** _____ **Age:** _____ **D.O.B.:** _____

Marital Status: **Married / Single / Divorced / Widow:** _____

Occupation: _____ **Primary Care Physician:** _____

Referring Physician or other: _____

2. **Please describe your present problem:** _____

3. **Have you received any prior treatment for this problem? What was the treatment and when?**

4. **Date of last period** _____

Total # of Pregnancies _____ # full term _____ # premature _____ # abortions _____

miscarriages _____ # living children _____ # vaginal deliveries _____ # c-sections _____

5. Sexually Active: **Yes / No**

6. **What method of birth control do you use?** _____

7. Smoke: **Yes / No** Drink: **Yes / No** Street Drugs: **Yes / No**

8. **GYN past history (✓)** and please explain below if necessary:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Abnormal Pap | <input type="checkbox"/> Laser | <input type="checkbox"/> Sexual Problem | <input type="checkbox"/> Ovarian Cysts |
| <input type="checkbox"/> Infections; discharge | <input type="checkbox"/> Leep | <input type="checkbox"/> Sexual Abuse | <input type="checkbox"/> Ovarian Cancer |
| <input type="checkbox"/> Genital Warts | <input type="checkbox"/> Heavy Periods | <input type="checkbox"/> I.U.D. <input type="checkbox"/> B.C. Pill | <input type="checkbox"/> Uterine Cancer |
| <input type="checkbox"/> Gonorrhea | <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"/> Urinary Leakage |

9. Date of last pap smear _____ Normal Yes / No, if no explain _____

10. Date of last mammogram _____ Where _____ Normal Yes / No, if no explain _____

11. **Surgeries & Years** (include colonoscopies) _____

Name: _____ **D.O.B.:** _____

12. **Medical Problems (✓) and circle. 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 #12 |
| <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 | <input type="checkbox"/> G.U. (bladder, kidneys, infections) |

13. **Family History** - Note which relatives have any of the following:

- | | | |
|----------------------------|----------------------|----------------------------|
| High Blood Pressure: _____ | Endometriosis: _____ | Alzheimers: _____ |
| Diabetes: _____ | Osteoporosis: _____ | Premature Menopause: _____ |
| Heart: _____ | Thyroid: _____ | Twins: _____ |
| Cholesterol: _____ | Kidney: _____ | Birth Defects: _____ |
| Other: _____ | | |

Please list any medications you may be taking and any allergies to medications along with the reaction you have.
(There is a page provided for this in your packet of paperwork)

Patient Signature	Date	Nurse / MD Signature	Date
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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?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

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.