GREATER BINGHAMTON
Obstetrics & Gynecology

**Dr. Leuci, Victoria McManus FNP, Nicole Rouhana FNP**

Patient Name: _____ Date of Birth: _____
Allergies and Reactions: _____
Reason for Visit: _____
_____
When was the first day of your last menstrual period? _____
Length of Menstrual Cycle: _____
Menstrual Flow: Light ____ Moderate ____ Heavy ____
Age of first menstrual cycle: _____
If you stopped having menstrual cycles, at what age did you have your last one? _____
Method of Birth Control: _____
Previous forms of birth control: _____
Partners: Male _____ Female _____ Both _____
Have you ever been treated for an STD? Yes ____ No ____ If yes, what/when? _____
Current Medications and Dosages (including over the counter):

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

When was your last pap smear? _____ Result: _____
Have you ever had an abnormal pap smear? Yes ____ No ____ If yes, when? _____
When was your last mammogram? _____ Result: _____
Have you had a bone density test? Yes _____ No _____ When/Result: _____
Have you had a colonoscopy? Yes _____ No _____ When/Result: _____
Have you completed the Gardasil Series? Yes _____ No _____

## Social History:

Do you smoke? Yes _____ No _____ If yes, how many and how frequently? _____
Do you vape? Yes _____ No _____ Milligram of Nicotine: _____ How Frequently? _____
Do you drink alcohol? Yes _____ No _____ If yes, how many and how frequently? _____
Do you use any illicit or recreational drugs? Yes _____ No _____ If yes, how frequently? _____
Do you exercise regularly? Yes _____ No _____ If yes, how frequently and for how long? _____
Do you feel safe at home? Yes _____ No _____ Would you like information on domestic violence resources?? Yes __ No __

## Personal Medical History:

Anemia: Yes _____ No _____
Anxiety: Yes _____ No _____
Asthma: Yes _____ No _____
Bleeding/Clotting Disorders: Yes _____ No _____
Cancer: Yes _____ No _____
Type of Cancer: _____
Depression: Yes _____ No _____
Diabetes: Yes _____ No _____
Epilepsy/Seizures: Yes _____ No _____
Endometriosis: Yes _____ No _____
Gastrointestinal Reflux: Yes _____ No _____
Heart Disease: Yes _____ No _____
High Cholesterol: Yes _____ No _____

Hypertension: Yes _____ No _____
Hyperthyroid: Yes _____ No _____
Hypothyroid: Yes _____ No _____
Migraines: Yes _____ No _____
With aura: Yes _____ No _____
Osteopenia: Yes _____ No _____
Osteoporosis: Yes _____ No _____
PCOS: Yes _____ No _____
Stroke: Yes _____ No _____

Other: _____
_____

**Surgical History:**

Date: _____ Procedure: _____ Physician/Hospital: _____

Date: _____ Procedure: _____ Physician/Hospital: _____

Date: _____ Procedure: _____ Physician/Hospital: _____

Date: _____ Procedure: _____ Physician/Hospital: _____

**Obstetrical History:**

Date: _____ Type of Delivery: _____ Male/Female: _____ Physician/Hospital: _____

Date: _____ Type of Delivery: _____ Male/Female: _____ Physician/Hospital: _____

Date: _____ Type of Delivery: _____ Male/Female: _____ Physician/Hospital: _____

Date: _____ Type of Delivery: _____ Male/Female: _____ Physician/Hospital: _____

**Family History:**

Breast Cancer: Yes _____ No _____
If Yes, Relative/Age of Onset: _____
Colon Cancer: Yes _____ No _____
If Yes, Relative/Age of Onset: _____
Ovarian Cancer: Yes _____ No _____
If Yes, Relative/Age of Onset: _____
Uterine Cancer: Yes _____ No _____
If Yes, Relative/Age of Onset: _____
Other Cancer: Yes _____ No _____
If Yes, Relative/Age of Onset: _____
Heart Disease: Yes _____ No _____
If Yes, Relative/Age of Onset: _____

High Blood Pressure: Yes _____ No _____
If Yes, Relative/Age of Onset: _____
High Cholesterol: Yes _____ No _____
If Yes, Relative/Age of Onset: _____
Stroke: Yes _____ No _____
If Yes, Relative/Age of Onset: _____
Diabetes: Yes _____ No _____
If Yes, Relative/Age of Onset: _____
Bleeding/Clotting Disorders: Yes _____ No _____
If Yes, Relative/Age of Onset: _____
Other:
_____
_____

**Review of Systems:** Please check 'yes' if any of the following apply to you.

**Urinary:**
Blood in Urine: Yes _____ No _____
Pain with Urination: Yes _____ No _____
Urinary Urgency: Yes _____ No _____
Urinary Frequency: Yes _____ No _____
Incomplete Emptying of Bladder: Yes _____ No _____
Urine loss with Cough/Laugh/Lift: Yes _____ No _____
Involuntary Urine Loss: Yes _____ No _____

**Gynecological:**
Abnormal Uterine Bleeding: Yes _____ No _____
Irregular Periods: Yes _____ No _____
Painful Periods: Yes _____ No _____
Painful Intercourse: Yes _____ No _____
Bleeding with Intercourse: Yes _____ No _____
Abnormal Vaginal Discharge: Yes _____ No _____
Vaginal Itching: Yes _____ No _____
Possible Contact with STD: Yes____ No _____

**Breasts:**
Pain in Breasts: Yes _____ No _____
Nipple Discharge: Yes _____ No _____
Mass/Lump in Breasts: Yes _____ No _____
Rash on Breasts: Yes _____ No _____

**Other Concerns:** _____
_____
_____
_____
_____
_____
_____

**Clinical:** (Please leave for office to complete)

**Age:** _____ **Height:** _____ **Weight:** _____
**BP:** _____ **LMP:** _____ **Birth Control:** _____

Last Pap Smear: _____ Result: _____
Last Mammogram: _____
Preferred Pharmacy: _____
Primary Care Physician: _____

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# PATIENT REGISTRATION

PATIENT NAME:_____DATE OF BIRTH:_____

PREFERRED TO BE CALLED BY: _____

ADDRESS:_____

HOME PHONE: (  )  -  CELL PHONE: (  )  -  WORK PHONE: (  )  -

SOCIAL SECURITY NUMBER:_____

PLACE OF EMPLOYMENT:_____

SPOUSE'S NAME:_____DATE OF BIRTH:_____

EMERGENCY CONTACT:_____ Phone Number:_____

PRIMARY CARE PHYSICIAN:_____

REFERRED BY:_____

Have you seen our?:

TV Commercial  Phonebook  Newspaper Ad  Website  Other_____

E-Mail Address: _____

## ASSIGNMENT OF INSURANCE BENEFITS

I authorize assignment of medical benefits to Greater Binghamton Obstetrics and Gynecology, PLLC and understand that I am financially responsible for balances not covered by my insurance. I certify that the information given by me is correct.

Signature:_____ DATE:_____

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| TODAY'S DATE: | NAME: | AGE: | DATE OF BIRTH: |
|---|---|---|---|
| | | | |

## Family History Questionnaire

**Please answer the following questions to the best of your knowledge to help your care team understand cancer patterns in your family. For more information, text EMPOWER to 484848.**

Select Yes/No and enter information in the accompanying boxes of the same row. Family members include parents, siblings, children, uncles, aunts, first cousins, grandparents, grandchildren, nieces, nephews, or half-siblings.

| Please complete the following for you and your family members: | | | Age at diagnosis | Enter family member and age at diagnosis | | |
|---|---|---|---|---|---|---|
| | | | You | Siblings/Children | Mother's side | Father's side |
| **Example:** | Breast cancer | ☒ Y ☐ N | Age 46 | Daughter, 23<br>Sister, 52 | Aunt, #1 63<br>Aunt, #2 48 | Grandma, 81 |
| 1. | Breast cancer ≤ age 45 **OR** breast cancer ≤ age 50 with unknown family history | ☐ Y ☐ N | | | | |
| 2. | Either colon cancer or uterine cancer < age 50 | ☐ Y ☐ N | | | | |
| 3. | Triple negative breast cancer ≤ age 60 | ☐ Y ☐ N | | | | |
| 4. | Two or more breast cancers in the same person (first diagnosis ≤ age 50) | ☐ Y ☐ N | | | | |
| 5. | Two or more colon and/or uterine cancers in the same person | ☐ Y ☐ N | | | | |
| 6. | Two family members with breast, colon or uterine cancer (one ≤ age 50) | ☐ Y ☐ N | | | | |
| 7. | Three or more family members from the same side with breast cancer | ☐ Y ☐ N | | | | |
| 8. | Three or more family members with colon and/or uterine cancer | ☐ Y ☐ N | | | | |
| 9. | Ovarian cancer **OR** pancreatic cancer **OR** male breast cancer **OR** 10 or more precancerous colorectal polyps | ☐ Y ☐ N | | | | |
| 10. | Ashkenazi Jewish **AND** breast cancer or high-grade prostate cancer | ☐ Y ☐ N | | | | |
| 11. | You or a close family member has a known gene mutation. Please list _____ | ☐ Y ☐ N | | | | |
| 12. | Other cancers not listed above _____ | ☐ Y ☐ N | | | | |
| 13. | Other concern about your cancer risk | ☐ Y ☐ N | Please explain: | | | |

### If you have never been diagnosed with breast cancer, please complete the following questions.

**1.** Height (ft/in) _____ **2.** Weight (lbs) _____ **3.** Have you had children? ☐**Y** ☐**N** How old were you when you had your first child? _____

**4.** Approximate age at first menstrual period? _____ **5.** Have you gone through menopause? ☐**Y** ☐**N** ☐**Ongoing** If yes, at approximately what age? _____

**6.** Are you of Ashkenazi Jewish descent? ☐**Y** ☐**N** ☐**I don't know**

**7.** Have you ever used hormone replacement therapy? ☐**Y** ☐**N** If yes, when? Start date _____ Ongoing? ☐**Y** ☐**N** End date _____

If yes, what type? ☐ **Estrogen** ☐ **Progesterone** ☐ **Combined**

**8.** How many sisters do you have? _____ Daughters? _____ Maternal aunts? _____ Paternal aunts? _____ ☐ **I don't know**

**9.** Have you ever had a breast biopsy? ☐**Y** ☐**N** If yes, what was the result? ☐ **Hyperplasia** ☐ **Atypical hyperplasia** ☐ **LCIS** ☐ **I don't know**

### Signatures

| Patient Name | Patient Signature | Date |
|---|---|---|
| | | |
| **Provider Name** | **Provider Signature** | **Date** |
| | | |

### For Office Use Only

A 'Yes' answer to any of questions 1–11 indicates your patient may meet criteria for hereditary cancer testing.

**Patient offered hereditary cancer genetic testing** (check all that apply)

☐ **Yes** ☐ **No** ☐ **Patient accepted** ☐ **Patient declined**

  201 Industrial Road, Suite 410 | San Carlos, CA 94070 | www.natera.com | 1.650.249.9090