Name:_____ DOB:_____ Date:_____

New Patient Paperwork

Dr. Grone- Beatrice Women's Clinic

Reason For Visit:_____

Please list all medications and vitamins that you take on a regular basis:

Medication Name	Dose	How Often

Preferred Pharmacy:_____

Allergies:

Medication	Reaction

Medical History (please circle):

Amenorrhea
OCP use
Breast problems
Perforation of Uterus
Dysmenorrhea
PID
Endometriosis
STD:_____
Female Infertility
Urinary incontinence
Fibroids
Uterine Bleeding - Abnormal
Genital warts
Uterus Window
IUD use
Vaginal discharge
Obstetrical Rupture Of Uterus
Anemia
Anxiety
Autoimmune disorder
Blood transfusion
Cancer:_____
Clotting disorder
Depression
Diabetes:_____
Digestive disorder
Epilepsy
Heart Murmur
HIV/AIDS
High Cholesterol
High Blood Pressure
Psychiatric Disorder
Respiratory Disorder
Seizures
Substance Abuse
Thyroid Disease
Other:_____
_____
_____
_____

Name:_____DOB:_____ Date:_____

Past Surgical History:

Procedure	Date	Doctor

Obstetric History (including miscarriages and/or abortions):

Date of Birth	Delivery Type	Gestational Age	Complications	Gender	Is the Child Living	Delivery Location/Provider

Family History: Has anyone in your family been diagnosed with the following (indicate who by using the following): M-Mother; F-Father; B-Brother; S-Sister; D-Daughter; S-Son; For the following please indicated P-Paternal M-Maternal: GM-Grandmother GF-Grandfather; A-Aunt; U-Uncle; C-Cousin

[]Stroke_____
[] Alcoholism_____
[]Asthma_____
[]Bleeding Problems, including blood clots_____
[]Cancer, breast_____
[]Thyroid Problems_____
[]Cancer, other_____
Type:_____
[]Diabetes_____
[]Headaches_____
[]Heart disease_____
[]Osteoporosis_____
[]High blood pressure_____
[]Kidney disease_____
[]Mental illness, including depression:_____
[]Osteoporosis_____

Alcohol: Yes Not Currently Never
If yes, how many drinks/day:_____

Recreational or Street Drugs: Yes Not Currently Never
If yes, what type and how often:_____

Tobacco: Current Former Never
If current, what type of tobacco (including E-cig) and how often:_____
Are you ready to quit?: Yes No

Sexual Activity: Yes Not Currently Never
Male Partner, Female Partner or Both?:_____Number of sexual partner(s) in the last year:_____

Sexual Orientation: Straight Bisexual Lesbian Choose Not To Disclose Don't Know Something Else

Gender Identity: Female Male Transgender Male(Female to Male)
Transgender Female (Male to Female) Choose not to disclose Other

Patient Name:_____DOB:_____Date:_____

Ambulatory Profile

Advanced Directives
Do you have an advanced directive or living will? YES NO
If you marked yes to the answer above, does BWCC have a copy in your chart? YES NO
Would you like more information on advanced directives? YES NO

Nutrition Screen
In the past two months have you had any unintended weight loss? YES NO

Vaccinations
Have you had any recent vaccinations? YES NO
If you answered YES to the above question, what vaccinations have you had? _____

PT/OT Screen
Have you had any recent decline in your mobility? (Please check all that apply, if any)
[ ]Unsteady Gait [ ]Transferring [ ]Dressing [ ]Bathing [ ]Toileting [ ]Falls [ ]Walking [ ] Climbing Stairs

Do you use any assistive devices? (Please check all that apply, if any)
*[ ] Cane [ ] Walker [ ] Toilet Riser [ ] Shower Chair [ ] Eyeglasses [ ] Contact [ ] Other:*_____

Cognitive and Functional Status
Are you deaf or do you have difficulty hearing? YES NO
Are you blind or do you have difficulty seeing, even when wearing glasses? YES NO
Do you have difficulty running errands alone such as shopping or visiting a doctor's office? YES NO

Depression Questionnaire
Over the past two weeks have you often had little interest or pleasure in doing things or felt down/depressed? YES NO

If you said yes to the above questions please answer the questions below using numbers 0-3. (If you said no you may skip this section.)

0 = Not at All 1=Several Days 2= More than Half of the Days 3= Nearly Every Day

Little interest or pleasure in doing things: _____
Feeling down, depressed, or hopeless: _____
Trouble falling asleep, staying asleep or sleeping too much: _____
Feeling Fired or having little energy: _____
Poor appetite or overeating: _____
Feeling bad about yourself-or that you are a failure or have let yourself or your family down: _____
Trouble concentration on things such as reading the newspaper or watching television: _____
Moving or speaking so slowly that other people could have noticed. Or the opposite-being so fidgety or restless that you have been moving around a lot more than usual: _____
Thoughts that you would be better off dead, or hurting yourself in some way: _____

If you said yes to any of these questions, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?
[ ] Not Difficult [ ] Somewhat Difficult [ ] Very Difficult [ ] Extremely Difficult

(OVER)

Patient Name:_____DOB:_____Date:_____

Home Care Planning

Current type of Residence: (Please check one)

[ ] Home Alone [ ] Home with Family [ ] Homeless [ ] Foster Home [ ] Group Home [ ] Assisted Living
[ ] Nursing Home [ ] Skilled Nursing Facility [ ] Other:_____

Support Systems: (Please check all that apply)

[ ] Spouse/Significant Other [ ] Parent(s) [ ] Children [ ] Other Family Members
[ ] Case manager/Social Work [ ] Church/Faith Community [ ] Friends/Neighbors [ ] Home Care Staff
[ ] Organized Support Group [ ] Therapist [ ] None [ ] Other:_____

Current Assistance at Home: (Please check all that apply)

[ ] None [ ] Supervised Setting [ ] Home Health Care [ ] Rehab [ ] Educational Support

[ ] Equipment [ ] ADL's [ ] Medications [ ] Respiratory Care [ ] In Home Health

Health Literacy Screening

How often do you have someone help you read or fill out health paperwork or medical material?(please check one)

[ ] Never (I always read/fill out my own paperwork) [ ] Sometimes [ ] Always

How often do you have problems learning about your medical condition? (Please check one)

[ ] Never (I always understand) [ ] Sometimes [ ] Always

Primary Learner Name:_____

Relationship (if other than self): _____

Do you have any learning barriers? (Please check all that apply)
[ ] Reading [ ] Language [ ] Visual [ ] Hearing [ ] Physical [ ] Emotional [ ] Cognitive
[ ] Spiritual [ ] Cultural [ ] Other: _____

How does the primary learner prefer to learn new concepts? *(Please check all that apply)*
[ ] Listening [ ] Reading [ ] Demo [ ] Pictures/Video

(OVER)

MYRIAD myRisk® Hereditary Cancer

Cancer Family History Questionnaire

Personal Information			
Patient Name	**Date of Birth**	**Healthcare Provider**	**Today's Date**

Instructions: Your personal and family history of cancer is important to provide you with the best care possible. Please complete the chart below based upon your personal and family history of cancer. Leave blank what you do not know.
The following relatives should be considered: Parents, siblings, half-siblings, children, grandparents, grandchildren, aunts, uncles, nieces and nephews on both sides of the family.

Do you have a personal history of:	Yes (Y) or No (N)?	Which cancer?	Age at diagnosis?
Breast, ovarian, or **pancreatic cancer** at any age	☐ Y ☐ N		
Colorectal or **uterine cancer** at 64 or younger	☐ Y ☐ N		

Do you have a family history of:	Yes (Y) or No (N)?	Which relative?	Maternal (M) or Paternal (P) side of the family?	Age at diagnosis?
Breast cancer at 49 or younger	☐ Y ☐ N		☐ M ☐ P	
Two **breast cancers** (bilateral) in one relative at any age	☐ Y ☐ N		☐ M ☐ P	
Three **breast cancers** in relatives on the same side of the family at any age	☐ Y ☐ N		☐ M ☐ P	
Ovarian cancer at any age	☐ Y ☐ N		☐ M ☐ P	
Pancreatic cancer at any age	☐ Y ☐ N		☐ M ☐ P	
Male breast cancer at any age	☐ Y ☐ N		☐ M ☐ P	
Metastatic prostate cancer at any age	☐ Y ☐ N		☐ M ☐ P	
Colon cancer at 49 or younger	☐ Y ☐ N		☐ M ☐ P	
Uterine cancer at 49 or younger	☐ Y ☐ N		☐ M ☐ P	
Ashkenazi Jewish ancestry with **breast cancer** at any age	☐ Y ☐ N		☐ M ☐ P	
Do you have a family history of **other cancers**?	☐ Y ☐ N	**List them here:**		
Have you or anyone in your family had genetic testing for hereditary cancer?	☐ Y ☐ N	**Who?**	**What gene(s)?**	**What was the result?**

Cancer Risk Assessment Review (to be completed after discussion with your healthcare provider)

Patient Signature _____ Date _____

Healthcare Provider Signature _____ Date _____

Office Use Only Patient offered hereditary cancer genetic testing? ☐ Yes ☐ No ☐ Accepted ☐ Declined

If yes, which test? ☐ BRAC*Analysis*® with Myriad myRisk® ☐ Multisite 3 BRAC*Analysis*® REFLEX to BRAC*Analysis*® with Myriad myRisk® ☐ COLARIS®PLUS with Myriad myRisk® ☐ COLARIS *AP*®PLUS with Myriad myRisk® ☐ Single Site Testing ☐ Myriad myRisk® Update ☐ Other: _____

Follow-up appointment scheduled? ☐ Yes ☐ No Date of next appointment: _____