Corewell Health™

Obstetrics and Gynecology
Angelique Ellison DO & Rebekah Sessoms DO & Max Izbicki DO

Patient Health History Questionnaire

Today's Date _____

Name _____ Birth Date _____ Age _____

Marital Status _____ Occupation _____

With whom can we discuss your care? (Please write name, relation, phone number)
To share with **no one,** check here { }

_____ ***Signature:*** _____

Primary Care Provider (Physician, PA, or NP) _____

How do you identify? □ Woman □ Trans man □ Non-binary □ Other_____

Please circle preferred pronouns: she/her he/him they/them

Reason for Visit:
□ Pap smear Date of last pap smear _____ Date of last mammogram _____
□ Pregnancy
□ Gynecologic issue (please describe) _____

Current Medications and Dosages *(please list including birth control)*

_____
_____

Preferred pharmacy _____ City/Street _____

Allergies and Reaction *(please list; if none, please write none)*

_____
_____

Medical History (please check all that apply to *YOU* only)

□ Anemia	□ Gallbladder disease	□ Hepatitis
□ Seizures	□ High blood pressure	□ Diabetes
□ High cholesterol	□ Thyroid disease	□ Blood clots in legs or lungs
□ Severe headaches/migraines	□ Heart disease	□ Heart murmur
□ Asthma	□ Bleeding disorders	□ Stroke
□ Sickle Cell	□ Breast lumps/discharge	

□ Mental/emotional problems, describe _____
□ Cancer (type)_____ date of diagnosis: _____ treatment:_____
□ Other problems/diseases not listed above _____
_____
□ Hospitalizations – describe (dates) _____
_____

Surgical History (please list any and all surgeries including type and dates)

_____
_____

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CONTINUED ON BACK

Family History

	Living/ Deceased	Cancer (type)	Diabetes	High Blood Pressure	Stroke / Mini Stroke	Blood Clots	Other
Mother							
Father							
Siblings (specify)							
Children							
Maternal Grandmother							
Maternal Grandfather							
Paternal Grandmother							
Paternal Grandfather							

Please list any family history of Female Cancers (Uterine, Ovarian, Breast)

_____

_____

Substance Use

Do you smoke cigarettes? { }No { }Yes, packs per day? _____ Do you smoke marijuana? { }No { }Yes
History of/current problems with alcohol and/or street drugs? { }No { }Yes, describe (please include type and treatment) _____
Do you vape/use e-cigarettes? { } No { } Yes, If so how often, what kind (nicotine, flavor, THC)_____

Gynecologic History

Are you currently sexually active? { }Yes { }No
What is your current method of birth control_____
Have you had an abnormal pap smear? { }No { }Yes, describe (dysplasia, HPV, high/ low grade)_____

Please check if you have any history of the following:

□ Endometriosis (date of surgical diagnosis_____) □ Polycystic Ovarian Syndrome
□ Herpes (1 or 2) □ Genital warts
□ Chlamydia □ Gonorrhea
□ Syphilis □ Trichomonas
Please describe any treatment for any of the above checked conditions:

_____

Menstrual History (please check all that apply)

□ Regular (every 21-35 days) □ Last longer than 7 days
□ Irregular □ Heavy □ Light
□ Severe cramping □ Bleeding between periods
Age periods began_____ First day of last period_____
If you are in menopause, year of menopause_____, any bleeding after menopause? _____

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CONTINUED ON NEXT PAGE

NAME:_____

Pregnancy History

Are you currently pregnant? _____ Total # of pregnancies_____ # of live births _____
# of miscarriages_____ # of abortions_____

In the box below, please list ALL pregnancies/losses and their outcomes*

Date of Delivery/Loss	Full/ Preterm	Boy/ Girl	Weight (lbs, oz)	Vaginal/ Cesarean	Complications? Where did you deliver?

Depression Screen

Over ***the last 2 weeks***, how often have you been bothered by the following problems? (Please check)

	Not at all 0	Several days 1	More than half of days 2	Nearly every day 3
1. Little interest or pleasure in doing things				
2. Feeling "down," depressed, or hopeless				
3. Trouble falling asleep **or** sleeping too much				
4. Feeling tired or having little energy				
5. Poor appetite **or** overeating				
6. Feeling bad about yourself **or** that you are a failure **or** have let yourself or your family down				
7. Trouble concentrating on things such as reading the newspaper or watching television				
8. 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				
9. Thoughts that you would be better off dead or hurting yourself in some way				

Is there anything else you would like us to know regarding your current health or health history?

_____

_____

_____

Please bring your completed paperwork back up to the front desk. We will review your information, enter it into the computer, and call you back shortly. Thank you!

Corewell Health™
(Previously BEAUMONT)

corewellhealth.org

Obstetrics & Gynecology Trenton
5400 Fort St. Suite 250
Trenton, MI 48183-4630

Dear Patient (Guardian)

To allow patients access to timely medical care and to ensure that each patient is allowed adequate time with their provider, we ask that you please be on time for your appointment. We do provide reminder phone calls two (2) days prior to your appointment to allow adequate time for rescheduling or cancellation if needed. If you cannot keep your appointment, we kindly ask that you call us at least 24 hours prior to your scheduled appointment if it needs to be cancelled or rescheduled. If you do not call to reschedule or cancel your appointment prior to two (2) hours before your scheduled appointment, we will consider this a missed appointment.

Should you arrive **15 minutes or later** to your appointment, you will be required to reschedule, and it will be counted as a no-show.

For procedure appointments only, we require you to arrive no later than your scheduled appointment time due to the length of this type of appointment. If you show up after your scheduled appointment time, we **will reschedule** your procedure. (This will not be marked as a no-show appointment).

In accordance with the BMG Patient Missed Appointment at Outpatient Practices Policy, if a patient has three (3) or more occurrences of missed appointments within the eight (8) most recent appointments at the office, the patient may be discharged from the practice, at the discretion of the provider.

New patients who miss two (2) or more appointments may be restricted from scheduling future appointments, at the discretion of the provider and practice leadership.

Signed,

Obstetrics & Gynecology Trenton

I _____, acknowledge this policy within Obstetrics & Gynecology Trenton.

Patient Name (Printed): _____

Patient Signature: _____

Guardian Signature (if applicable): _____

Date: _____