Elizabeth Etkin-Kramer, M.D., F.A.C.O.G.: **Interval Medical History**

Have you been diagnosed with any new medical problems, or worsening of existing problems? _____
_____

Have you had any surgeries, procedures or pregnancies since your last visit? _____

Are you taking any new medicines? _____

Is there anything new in your FAMILY HISTORY?_____

Please note if any of the following has been a new or reoccuring issue for you since your last visit:

CONSTITUTIONAL
- ❑ Fever
- ❑ Weight loss
- ❑ Weight gain
- ❑ Excessive fatigue

EYES
- ❑ VISION CHANGE
- ❑ GLASSES

ENT
- ❑ Hearing loss
- ❑ Sinus problems
- ❑ Mouth Sores

CARDIOVASCULAR
- ❑ Chest pain
- ❑ Difficulty breathing
- ❑ Palpitations
- ❑ Leg swelling

RESPIRATORY
- ❑ Shortness of Breath
- ❑ Wheezing
- ❑ Cough

GASTROINTESTINAL
- ❑ Nausea/vomiting
- ❑ Constipation
- ❑ Diarrhea
- ❑ Blood in Stool

GENITOURINARY
- ❑ Blood in Urine
- ❑ Pain with urination
- ❑ Frequent urination
- ❑ Painful intercourse
- ❑ Abnormal vaginal bleeding

BREAST
- ❑ Rash or skin lesions
- ❑ Breast Mass
- ❑ Breast Pain
- ❑ Nipple Discharge

NEUROLOGIC
- ❑ Numbness
- ❑ Dizziness
- ❑ Seizures

PSYCHIATRIC
- ❑ Depression
- ❑ Severe Anxiety

ENDOCRINE
- ❑ Hot Flashes
- ❑ Thyroid problems
- ❑ Diabetes

HEMATOLOGIC/LYMPHATIC
- ❑ Abnormal bleeding
- ❑ Abnormal bruising
- ❑ Enlarged lymph nodes

MUSCULOSKELETAL
- ❑ Muscle weakness
- ❑ Muscle or joint pain

Please Review and INITIAL where appropriate:

Cervical Cancer Screening: There are new and improved ways of screening for cervical cancer
Age 21-29: pap smear
Age 30-65: pap and HPV done ("cotesting"). If both Pap and HPV are negative, we do NOT repeat cervical screening for 2-3 years. ****this does not apply if we are following an abnormal pap smear every 6 mo.
Age 65+: screening individualized. Please note that Medicare covers routine Pap smears every OTHER year and does not cover HPV cotesting.
Cervical cultures: CDC recommends testing all women under the age of 25 for chlamydia with or without gonorrhea. Over the age of 25, we would recommend testing if you have any risk factors, like anew partner. Testing is done at the time of your Pap smear. Most, but not all, insurances cover these important tests. Like any other test, if the laboratory receives an insurance denial for these tests, you will be responsible for payment.

□ I request chlamydia and gonorrhea testing **□ I decline chlamydia and gonorrhea testing**

Other STIs: CDC and ACOG recommend yearly HIV testing in patients with any risk factors; eg, new partners in the past year. This is done by a blood test and can be combined with testing for other sexually transmitted infections such as syphilis, hepatitis b and c, and sometimes Herpes type 2 antibody testing.

□ I request blood testing for above STIs **□ I decline blood testing for above STIs**

Colon Cancer screening: Gastroenterology societies recommend to begin screening for colon cancer after age 50 for the average Caucasian patient and age 45 in the African American population. If you have not had a colonoscopy recently, we can check your stool for blood during the gynecologic exam; Most insurances (except NHP) cover this, but if your insurance denies reimbursement, you will be responsible for payment ($25)

□ I request fecal immunological blood testing **□ I decline fecal immunological blood testing**

Patient Name: _____ Date: _____/_____/_____

Signature: _____

Elizabeth Etkin-Kramer, M.D., F.A.C.O.G.: Updated Demographics

Name: _____ Today's Date: _____

Social Security # _____ Date of Birth: _____

Home Address: _____ Home Phone: _____

City: _____ State: _____ Zip: _____ Cell Phone: _____

Occupation: _____ □ full time student Work Phone: _____

Employer/School: _____ **Email address**: _____

Work/school address: _____City: _____ State: _____ Zip: _____

Marital status: □ Married □ Single □ Divorced □ Widowed □ Domestic Partnership Sign Other's Name: _____

Spouses Employer (if applicable): _____ Address: _____

City: _____ State: _____ Zip: _____ Telephone: _____

Emergency Contact Information:

Name: _____ Relationship: _____ Telephone number: _____

Please list family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operations).

Name: _____ Relationship: _____ Telephone number: _____

Insurance Information

Insurance Plan: _____ **ID#** _____ **Group#** _____