COVA ob/gyn

Health Questionnaire

Name_____ **Date:**_____

Reason for today's Visit:_____

Allergies:_____

Vitals (by medical staff)

*BP:*_____ *Wt:*_____ *Ht:*_____

Age of first Menstrual Cycle: _____

Do you still have a menstrual cycle? Y N

If no please explain: _____

Date of Last Period:_____

Age @ birth of first child: _____

 # Of total Pregnancies:_____

Living Children:_____ **Miscarriages**_____
Abortions _____ **#Vaginal Births**_____
#Cesarean Births _____

Health Maintenance Questions

Last Pap:_____ **History of abnormal Paps?** Y / N

Last Mammogram:_____

Last Colonoscopy:_____

Last Dexa Scan:_____

Last Cholesterol:_____

History of STDs? Y N *if Yes please list

_____

Have you ever had a breast biopsy? Y / N

If Yes, what was the diagnosis?_____

_____

Medication History

Please include any medications you are taking:

Medical History

Please include any past medical history:

Surgical History

Please include any past surgical history w/ year:

Family History

Please include any family history to include, Breast/ovarian/colon:

Do you Smoke? Y N
Drink Alcohol? Y N
Illegal Drugs? Y N
Sexually Active? Y N w/ Male or Female

Birth Control Method:_____

Pharmacy:

Choice:_____

Location:_____

Cancer Risk Assessment Questionnaire

Patient Name: _____ Date of Birth: _____ Today's Date: _____

Reason for visit: _____ Physician today: _____ Email: _____

Instructions: Your physician **NEEDS** this information to perform an accurate assessment of your medical & cancer risks. Answer the questions by circling *YES or NO. If you circle YES, provide the relationship of the family member with the illness/cancer **and** their **age*** at diagnosis. Please consider the following relatives:

Mother/Father/Sisters/Brothers/Children (**1st degree relatives**),
Aunts/Uncles/Grandparents/Nieces/Nephews (**2nd degree relatives**),
1st Cousins/Great-Grandparents (**3rd degree relatives**)

QUESTIONS			SELF Age of Diagnosis	RELATIVES on MOTHER'S SIDE (Include Age of Diagnosis)	RELATIVES on FATHER'S SIDE (Include Age of Diagnosis))
***EXAMPLE:** Have you or any relatives been diagnosed with breast cancer under age 50?*	(YES)	NO	55	Mother, 45	Grandmother, 60 Aunt, 75
Have you or any relatives been diagnosed with breast cancer **under age 50**?	YES	NO			
Have you or any relatives been diagnosed with ovarian cancer at **any age**?	YES	NO			
Do you have **2** relatives with breast cancer, on the same side of family, **one at age 50 or younger**?	YES	NO			
3 or more breast cancers, on same side of family, **at any age**?	YES	NO			
Male breast cancer at **any age**?	YES	NO			
Pancreatic cancer at **any age**?	YES	NO			
Jewish ancestry, with breast cancer any age?	YES	NO			
Any relative with colon **or** uterine (endometrial) cancer **under age 50**?	YES	NO			
2 relatives, on same side of family, with colon **or** uterine cancer, **one at age 50 or younger**?	YES	NO			
Have **you** been diagnosed with colon or uterine cancer **under age 65**?	YES	NO			

Have you or a family member had genetic testing for a BRCA or Lynch mutation? (myRisk test) YES / NO If yes, who: _____

Patient Signature: _____ **Date:** _____

Healthcare Provider Signature: _____ **Date:** _____

Meets testing criteria: ☐ **Yes** ☐ **No** / ☐ **Recommended genetic testing:** ☐ **Accepted** ☐ **Declined** / ☐ **Will consider /follow up date:**_____

Patient Declined = *I acknowledge that I have been fully advised by my healthcare provider that my refusal to undergo the recommended testing may delay or prevent diagnosis and treatment of significant illness, including cancer, and that I am at increased risk of serious disease or death.* **Patient Declined Signature:** _____

COVA
medspa
The Complete Beauty & Aesthetic Practice

Dr Jennifer Cova, Medical Director

Cosmetic Interest Questionnaire

Are you interested in learning more about the following? (please check all that apply)

Lines/wrinkles

Botox: yes no

Juvederm/ Dermafillers: yes no

Laser Sun Resurfacing: yes no

Medical grade skin care and treatments

1. SkinMedica, medical grade skincare: yes no
2. Dermaplaning: yes no
3. Microdermabrasion: yes no
4. Chemical peels: yes no
5. Hydrafacial MD: yes no

Would you like a complimentary skin analysis?: yes no

Body, Contouring, and Weight loss

1. Coolsculpting: yes no
2. HCG medical weight loss program: yes no
3. B-Lipotropic Slim Shots: yes no