PLEASE HELP US UPDATE YOUR MEDICAL HISTORY SINCE YOUR LAST VISIT

PATIENT NAME: _____ _____ _____
Date Date of Birth

Who is your current Primary Care Physician: _____?

First Day of last period: _____ / _____ / _____
Month Day Year

Date of last pap smear: _____ / _____ / _____
Month Day Year

Date of last mammogram: _____ / _____ / _____
Month Day Year

Allergies:_____

Current Medication (including dosage)/Herbal meds, vitamins, calcium, etc:

_____

_____

_____

Any new medical problems or surgeries since your last visit?

_____

_____

_____

New family illnesses or cancers (name relative & related problem):

_____

_____

_____

What are you doing to prevent pregnancy? Circle one below:

Pills, Patch, Ring, IUD, Implanon, Condoms, Vasectomy, Withdraw, Hysterectomy, Tubal, Abstinence, other

_____.

Are you considering getting pregnant in the next year or so? □ Yes □ No □ Unsure

DO YOU *CURRENTLY* HAVE OR HAVE YOU *RECENTLY* HAD:

CONSTITUTIONAL

Fatigue	□ No	□ Yes
Fever	□ No	□ Yes
Night Sweats	□ No	□ Yes
* Insomnia	□ No	□ Yes
* Irritability	□ No	□ Yes

HEENT

Eye Discharge	□ No	□ Yes
Visual Loss	□ No	□ Yes
Ear Discharge	□ No	□ Yes
Hearing Loss	□ No	□ Yes
Nasal Drainage	□ No	□ Yes

RESPIRATORY

Cough	□ No	□ Yes
Difficulty Breathing (Dyspnea)	□ No	□ Yes
Wheezing	□ No	□ Yes

CARDIVASCULAR

Chest Pain	□ No	□ Yes
Irregular Heartbeat/palpitation	□ No	□ Yes

VASCULAR

Calf pain with activity (Claudication)	□ No	□ Yes

GASTROINTESTINAL

Abdominal Pain	□ No	□ Yes
* Bloating	□ No	□ Yes
Constipation	□ No	□ Yes
Diarrhea	□ No	□ Yes
* Nausea	□ No	□ Yes
Vomiting	□ No	□ Yes

GENITOURINARY

Painful Urination (Dysuria)	□ No	□ Yes
* Frequent Urination	□ No	□ Yes
Bloody Urination (Hematuria)	□ No	□ Yes
Excessive Urination (Polyuria)	□ No	□ Yes
Urgency	□ No	□ Yes
Urinary Incontinence	□ No	□ Yes

*Absence of Periods (Amenorrhea)	□ No	□ Yes
Excessively Painful Periods (Dysmenorrhea)	□ No	□ Yes
Excessively Heavy Periods (Menorrhagia)	□ No	□ Yes
* Breast Discharge	□ No	□ Yes
* Breast Lumps	□ No	□ Yes
* Breast Pain	□ No	□ Yes
* Painful Intercourse (Dyspareunia)	□ No	□ Yes
* Uterine Fibroids	□ No	□ Yes
* History of Abnormal Pap Smear	□ No	□ Yes

If yes, results & year: _____

* History of Infertility	□ No	□ Yes
* History of Ovarian Cysts	□ No	□ Yes
* Sexual Dysfunction	□ No	□ Yes
* Vaginal Itching	□ No	□ Yes
* Vaginal Discharge	□ No	□ Yes

METABOLIC/ENDOCRINE

Cold Intolerance	□ No	□ Yes
Heat Intolerance	□ No	□ Yes
Excessive Thirst (Polydipsia)	□ No	□ Yes
Excessive Hunger (Polyphagia)	□ No	□ Yes

NEUROLOGICAL/PSYCHIATRIC

Decreased Memory	□ No	□ Yes
Gait Disturbance	□ No	□ Yes
* Headaches	□ No	□ Yes

DERMATOLOGIC

* Itching (Pruritus)	□ No	□ Yes
Rash	□ No	□ Yes
* Change in Mole	□ No	□ Yes

MUSCULOSKELETAL

Muscle Weakness	□ No	□ Yes
Bone/Joint Symptoms	□ No	□ Yes

HEMATOLOGIC/LYMPHATIC

Easy Bleeding	□ No	□ Yes
Easy Bruising	□ No	□ Yes

IMMUNOLOGIC

Environmental Allergies	□ No	□ Yes

Please list: _____

Food Allergies	□ No	□ Yes

Please list: _____

I affirm that the information I have given is correct to the best of my knowledge. This information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

_____ _____ _____

Signature DOB Date