PATIENT HISTORY FORM – ANNUAL UPDATE

Name _____ Today's Date: _____

Date of Birth: _____ Daytime Phone (best number to be reached)_____

Current Mailing Address: _____

Marital Status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

MEDICATIONS: Please list all medications you are on.
Include: Prescription, Over-the-Counter, Vitamins, and "natural" or "Chinese" medication.

Medication	Dose	How Often?	The Doctor who prescribed?

ALLERGIES: (Medications, foods, dyes, latex)

Allergy/Sensitive to:	Reaction

MEDICAL HISTORY:

Tobacco Use: ☐ Current Smoker, how many a day?_____ ☐ Former Smoker, how long since?_____ ☐ Never

Last Menstrual Period_____, In Menopause? ☐ Yes ☐ No, Had a Hysterectomy? ☐ Yes ☐ No

Are you currently using any type of Birth Control? ☐ Yes ☐ No, if yes what kind? _____

List any problems or remarks about your period: _____

Have you had any Surgeries or been Hospitalized for anything since your last visit? ☐Yes ☐No, if yes please list date and type: _____

Have you ever been diagnosed with any of the following?

☐ Thyroid Disease	☐ Liver Disease	☐ Hepatitis	☐ Herpes
☐ Kidney Disease	☐ Diabetes - Type I or II	☐ HPV/Condyloma	☐ Chlamydia
☐ High Blood Pressure	☐ Insulin Resistance	☐ Abnormal Pap Smear	☐ Gonorrhea
☐ Asthma	☐ Emphysema	☐ Cancer: _____	☐ HIV
☐ Heart Disease	☐ Epilepsy or Seizures	☐ Other: _____	☐ Syphilis

DON'T FORGET TO FILL OUT THE BACK!!

REVIEW OF SYSTEMS: Please check the medical conditions or symptoms that apply to you:

GENERAL:

- ☐ Unexplained Weight Change
- ☐ Long-Lasting Fever
- ☐ Loss of Appetite

DERMATOLOGY:

- ☐ New or Changing Moles
- ☐ Skin Cancer
- ☐ Itching

ENDOCRINOLOGY:

- ☐ Excessive Thirst
- ☐ Excessive Urination
- ☐ Excessive Hunger

FEMALE REPRODUCTIVE:

- ☐ Pelvic Pain
- ☐ Abnormal Vaginal Discharge
- ☐ Pain with Intercourse
- ☐ Breast Pain
- ☐ Nipple Discharge
- ☐ Marked change in Sexual Drive
- ☐ Breast Lumps
- ☐ Abnormal Periods
- ☐ Heavy Bleeding
- ☐ Cramping

GASTROENTEROLOGY:

- ☐ Abdominal Pain
- ☐ Blood in Stool
- ☐ Change in Bowel Habits
- ☐ Bloating

HEMATOLOGY/LYMPH:

- ☐ Recent Swollen Glands
- ☐ Easy Bleeding
- ☐ Anemia

PSYCHIATRIC REVIEW:

- ☐ Depression
- ☐ Mood Swings
- ☐ Sleep Disturbance

RESPIRATORY:

- ☐ Chest Pain
- ☐ Short of Breath when you lie down
- ☐ Snoring

UROLOGY:

- ☐ Difficulty Urinating
- ☐ Frequent Urination
- ☐ Urinary Incontinence (wetting self)
- ☐ Frequent Bladder Infections

associates in WOMEN'S health OBGYN