Patient ID # _____ Date: _____

ASSOCIATES IN women's health obgyn specialists

Patient Medical History Update

Patient Name: _____ DOB: _____

Age: _____ Date of last annual exam: _____ 1st day of last period: _____

Primary Care MD: _____ Referring MD: _____

Gynecological History

Please check if anything listed applies to you:

Urine: ☐ Frequency ☐ Urgency ☐ Burning ☐ Incontinence ☐ Pain

Vagina: ☐ Dryness ☐ Itching ☐ Discharge ☐ Painful Intercourse ☐ Bleeding after intercourse

Menstrual: ☐ Irregular periods ☐ Cramps ☐ Heavy periods

Menopause: ☐ Hot Flashes ☐ Night Sweats ☐ Bleeding ☐ Insomnia ☐ Other_____

STD: ☐ AIDS/HIV ☐ Chlamydia/Gonorrhea ☐ Genital Warts ☐ Herpes ☐ Cancer History_____

Are you sexually active? ☐ Yes ☐ No Do you have multiple sexual partners? ☐ Yes ☐ No

Partners in Last Year_____ # Lifetime Partners_____ Is/Are your partner(s) ☐ Male ☐ Female ☐ Both

Is anyone physically, sexually, or emotionally hurting you? ☐ No ☐ Yes, Who? _____

History of sexual abuse? ☐ No ☐ Yes, When? _____

Current Contraception (including tubal ligation, vasectomy, condoms, etc.) _____

Current Review of Systems

Please check if you are now or recently have experienced any of the following:

Constitutional:	☐ Fatigue	☐ Sweating	☐ Unusual Weight Gain	☐ Unusual Weight Loss	
Eyes:	☐ Double Vision	☐ Spots	☐ Vision Loss		
Ear/Nose/Throat:	☐ Ringing in Ear	☐ Earache	☐ Sore Throat	☐ Bleeding Gums	☐ Congestion
Cardiac:	☐ Chest Pain	☐ Palpitations	☐ Swelling/Edema (location):_____		
Respiratory:	☐ Wheezing	☐ Cough	☐ Shortness of Breath		
GI:	☐ Constipation	☐ Diarrhea	☐ Bloating	☐ Black or Bloody Stools	
Muscle:	☐ Joint Pain	☐ Muscle Cramps	☐ Weakness		
Skin:	☐ Rash	☐ Dryness	☐ Lesions	☐ Acne	☐ Moles
Breast:	☐ Lump	☐ Fibrocystic	☐ Discharge	☐ Skin Changes	☐ Pain
Neuro:	☐ Headaches	☐ Tremors	☐ Weakness	☐ Seizures	
Endocrine:	☐ Excess Thirst	☐ Hair Loss	☐ Hair growth	☐ Cold/Heat Intolerance	
Lymph:	☐ Bruising	☐ Nosebleeds	☐ Swollen Glands		
Psych:	☐ Anxiety	☐ Depression	☐ Mood Swings	☐ PMS/PMDD	☐ Eating Disorder

Continued on reverse side

Social History

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

Are you employed? ☐ No ☐ Yes, Where: _____ Position: _____

Do you have carbon monoxide indicators in your home? ☐ Yes ☐ No

Do you have smoke detectors in your home? ☐ Yes ☐ No

Do you use street drugs? ☐ No ☐ Yes ☐ Marijuana ☐ Other Quantity/Frequency:_____

Do you use alcohol? ☐ No ☐ Yes, Amount: _____ Tobacco/e-cig products? ☐ No ☐ Yes, Amount: _____

Exercise: ☐ None / Routine of: _____ Do you wear seat belts? ☐ Yes ☐ No

Special diet: ☐ None ☐ Weight Loss ☐ Low Fat ☐ Gluten Free ☐ Vegan ☐ Diabetic ☐ Vegetarian ☐ Low Carb

Do you drink caffeinated beverages? ☐ No ☐ Yes, Quantity/Frequency:_____

Please list current medications you are taking along with the strength and dose.

MEDICATION	STRENGTH	DOSE

What concerns do you want to discuss at today's appointment? _____

_____

Were you or any family member diagnosed with a new medical condition since your last visit? _____

_____

Have you had any surgeries or hospitalizations since your last time here? ☐ Yes ☐ No

If yes, (who/where): _____

Do you have specific requests for:

☐ New Medication(s): _____
☐ Refills: _____
☐ Vaccinations: _____
☐ Referrals: _____
☐ Tests: _____
☐ Completion of forms: _____
☐ School or work release: _____
☐ Other: _____

Patient's Signature: _____ Date: _____ 3/2017