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Annual Gynecological Update

Name: _____ DOB: _____ Date: _____

Welcome Back! Please take a few minutes to complete this form to help us update your records.

Reason for today's visit? Annual Exam Problem: Explain _____

Please list any new medical problems: _____

What was the first day of your last period? _____

Please list any new surgeries since your last visit: _____

Any new medical problems in your family? _____

Who is your Primary Care Provider: _____

Primary Care Phone number: _____

Allergic to latex? Yes No

Do you smoke cigarettes? Yes No If so, how much per day? _____

Do you drink alcohol? Yes No If so, how much per day? _____

Do you use street drugs? Yes No Problems with violence at home? Yes No

Please check all that apply:

- | | | | |
|---------------------|--|---|---|
| <i>General:</i> | <input type="checkbox"/> Weight loss | <input type="checkbox"/> Weight gain | <input type="checkbox"/> Fever |
| <i>HEENT:</i> | <input type="checkbox"/> Vision changes | <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Sore throat |
| <i>CV:</i> | <input type="checkbox"/> Chest pain/pressure | <input type="checkbox"/> Irregular heartbeat | <input type="checkbox"/> Swelling of legs |
| <i>Resp:</i> | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Chronic cough | <input type="checkbox"/> Spitting of blood |
| <i>GI:</i> | <input type="checkbox"/> Bloody stool | <input type="checkbox"/> Nausea/indigestion | <input type="checkbox"/> Vomiting |
| <i>Urinary:</i> | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Painful urination | <input type="checkbox"/> Loss of urine |
| <i>MS:</i> | <input type="checkbox"/> Muscle pain | <input type="checkbox"/> Joint pain | <input type="checkbox"/> Swelling of joint(s) |
| <i>Skin:</i> | <input type="checkbox"/> Rash | <input type="checkbox"/> Change in color/size of mole | <input type="checkbox"/> Diarrhea |
| <i>Neuro/psych:</i> | <input type="checkbox"/> Headaches | <input type="checkbox"/> Depression/crying spells | <input type="checkbox"/> Fatigue |

Do you perform monthly Self Breast Exams? Yes No

Last cholesterol check: _____ Last Bone Density testing: _____

For those over 40, date of last sigmoidoscopy/colonoscopy/stool checked for blood: _____

Does your insurance cover routine, preventative gynecological care? Yes No

What Pharmacy do you use for prescriptions? _____

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS QUESTIONNAIRE. IT WILL HELP US PROVIDE YOU WITH BETTER CARE

revised 5/20sb