M A G N O L I A

– O B / G Y N –

TRACY D. NELSON M.D., F.AV.C.O.G. | KARYN C. MARKLEY M.D., F.A.C.O.G. | TRACEY A. GOLDEN M.D., F.A.C.O.G. | JESSICA C. BROWN M.D., F.A.C.O.G. | KAREN THOMPSON D.N.P., W.H.N.P. | KATHRYN O'DONALD W.H.N.P., B.C.

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? _____

Please list all current medications: _____

Please list all allergies to medications: _____

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:

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