PATIENT HISTORY UPDATE FORM

(Please Print)

YOUR NAME (Last) _____ (First) (M.I.)

Date of Birth _____ Provider:

Emergency contact _____ Relationship _____ Phone _____

I attest that the information here is true and correct to the best of my belief.

_____ _____

Patient Signature Date

GYNECOLOGIC HISTORY

Heavy periods, irregularity, spotting, pain or discharge	Yes No
Are you pregnant or breastfeeding?	Yes No
Any urinary tract, bladder, or kidney infections within the last year?	Yes No
Any problems with control of urination?	Yes No
Any hot flashes or sweating at night?	Yes No
Experienced any recent breast tenderness, lumps, or nipple discharge?	Yes No
Are you sexually active?	Yes No
If yes, are you trying to get pregnant?	Yes No
Any discomfort with intercourse?	Yes No

Date of last mammogram: Date:_____ Result:_____

PERSONAL HEALTH HISTORY

Any medical problems that other doctors have diagnosed? none

Date	Problem	Doctor

Recent Surgeries? none

Date	Problem	Doctor

Other recent hospitalizations? none

Date	Problem	Doctor

FAMILY HEALTH HISTORY

New significant medical problems in your family? none

Family Member	Condition or illness	Hospital

Do you have any known medication allergies? _____YES _____ NO

Allergies to:	Reaction:

List all medications you are currently taking.

Drug name	Dose	How Often	Start/Stop Date	Prescribed by

Primary Pharmacy Name _____

Any over-the-counter vitamins, supplements or herbs you are taking? none

_____

MENSTRUAL HISTORY

IF YOU ARE STILL MENSTRUATING, PLEASE ANSWER THESE QUSTIONS (If not, skip to next question):

First day of your last menstrual period? _____Are you certain of the date? _____

Cycle interval (28 days or ?) _____# of days of bleeding with a period _____

How heavy is the flow? Light Medium Heavy

Do you use contraception? _____ If so, what type? _____

IF MENOPAUSAL, PLEASE INDICATE STATUS:

PREMENOPAUSAL POSTMENOPAUSAL PERIMENOPAUSAL SURGICAL MENOPAUSE (HYSTERECTOMY)
AGE AT MENOPAUSE_____

Your age at last menstrual period? _____ Are you on hormone replacement? _____

Have you had any bleeding since menopause? _____

Are you sexually active? _____ Number of current partners? _____

SOCIAL HISTORY

Occupation:_____ Marital/Partner Status:_____

Spouse/Partner's name: _____ Spouse/Partner's occupation: _____

Caffeine Use: Yes No How Much: _____

Tobacco Use: Yes No How Much: _____

Alcohol Use: Yes No How Much: _____

"Recreational" Drug Use: Yes No Which Drug(s): _____

How Often: _____ Date when last used: _____

Exercise Habits: Active but no formal exercise Heavy amount of exercise (4 or more times weekly)

Moderate amount of exercise (1-3 times weekly) Minimal amount of exercise (Once weekly or less) Sedentary

Type of exercise: _____

_____

Are you in an abusive relationship now? _____Yes _____No

Indicate which: Emotionally Physically Sexually

Have you received counseling for this? _____Yes _____No

List any sources of chemical or radiation exposure you have recently encountered: _____

Are you at risk for travel-related illness? _____Yes _____No Explain: _____

Do you wear your seatbelt? _____Yes _____No

Notes: _____

_____

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