Annual Update

For office use only	Abstracted (Y / N)

Date: _______________________ DOB:___________________

Full Name (First, Middle, Last):______________________________ Nickname: ____________ Age: _______

Primary Care Physician: ____ Phone _________________________

Be aware that insurance companies do not allow you to be seen for *pap/annual/wellness care on the same day* that you have a specific complaint/problem that needs to be addressed.

List all current medications None _______

Medication	Dose

Drug Allergies: None ________

Drug	Reaction

Herbal Supplements ___________________________________ Vitamins Y / N Calcium Y / N

Current Medical Problems

Condition/Treatment	Date

Surgery in past two years

Procedure	Date

Review of Systems - Any Complaints with (Y/N)

Heart	Yes	No
Lungs	Yes	No
Breasts	Yes	No
Bowels	Yes	No
Kidneys/Bladder	Yes	No
Headache	Yes	No
Vaginal Area	Yes	No
Joints	Yes	No
Skin Problems	Yes	No
Weight	Yes	No
Vision/Hearing	Yes	No

Do you have any bladder concerns (leaking, pain, etc)? Y / N

Are you allergic to Latex? Y / N

GYN History

LMP ____________ Menstrual Cycle: Regular / Irregular # of days bleed ______________

Onset of Menopause (year) _________ Do you want to be checked for STDs? Y / N

Have you had an abnormal pap in the past 10 years? Y / N

Are you finished having children? Y / N

Social History

Do you smoke? Y / N Amount Daily _________ How many years _________

Alcohol Use? Daily / Occasionally / Rarely / Never

Health Maintenance History

	Never	Date of Last	Abnormal Results/ Date & Treatment
PAP Smear			
Mammogram			
Dexa Scan (Bone Density)			
Cholesterol			
Colonoscopy			

Family History: No family History available ________________ I am adopted ______________

Condition	**Yes or No**	**Which Relative**
Heart Problems		
High Blood Pressure		
Diabetes		
Breast Cancer		
Ovarian Cancer		
Colon Cancer		
Other Conditions		