PATIENT ANNUAL UPDATE

Name _____ Date: _____

What brings you to our office today? _____

Date of your last period? _____ Last Pap Test? _____ Last Mammogram? _____

Do you use a method of contraception? ☐ Yes ☐ No Do you use it regularly? Are you and your partner satisfied with this method? ☐

If yes, what type? (please circle one) Pills IUD Diaphragm Condoms Natural/Rhythm Sponge Spermicide

	Yes	No		
Has there been a change in your periods?	☐	☐		
Do you smoke cigarettes?	☐	☐		
Do you drink alcohol?	☐	☐		
Have you had any recent illnesses or surgery?			List:	1. _____
				2. _____
Are you taking any prescriptions medications? Please include all herbal products (prescription and non-prescription)	☐	☐	Drug/dose:	1. _____
				2. _____
				3. _____
Are you taking any vitamins/calcium?	☐	☐	Drug/dose:	1. _____
				2. _____
				3. _____
Are you allergic to any medications?	☐	☐	List:	1. _____
				2. _____

PLEASE CHECK ANY OF THE FOLLOWING DISORDERS THAT YOU OR SOMEONE IN YOUR FAMILY MAY HAVE.

☐ Breast Cancer ☐ Anemia ☐ Stroke
☐ High Blood Pressure ☐ Hepatitis
☐ Colon Cancer ☐ Blood Clots In Veins
☐ Diabetes ☐ Osteoporosis

PLEASE CHECK ANY OF THE FOLLOWING TESTS THAT YOU DESIRE TO HAVE AS PART OF YOUR EXAMINATION TODAY.

☐ Cholesterol Screening ☐ STD Screening (sexually transmitted disease)
☐ Stool Blood Test ☐ Diabetes Screening
☐ Osteoporosis Screening

Do you have any other questions or comments today?

Have there been any changes in your address, job, or insurance? ☐ Yes ☐ No

If so, please list _____
