

**OB-GYN, P.C.  
ANNUAL UPDATE FORM**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Date \_\_\_\_\_

Over the past 2 weeks, how often have you been bothered by the following problems?

	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling down, depressed or helpless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Current Medications (please list name of medication and dosage): \_\_\_\_\_

I authorize OB-GYN, P.C. to obtain my prescription history (Initial): \_\_\_\_\_

Allergies/Sensitivities to Medications, food, latex (please list): \_\_\_\_\_

**Gynecological Update**

First day of last menstrual period	How often do you have a period?	How long do periods last?	Periods are <input type="checkbox"/> Light <input type="checkbox"/> Average <input type="checkbox"/> Heavy	Are periods painful? <input type="checkbox"/> Yes <input type="checkbox"/> No Medication used:
_____	_____	_____		_____
_____	_____	_____		_____

Do you think of yourself as:  Straight or heterosexual  Gay, lesbian or homosexual  Bisexual  Something Else  I don't know  
 Prefer not to answer

Number of Sexual Partners in the past 12 months: \_\_\_\_\_ male(s) \_\_\_\_\_ female(s)

Sexual Practices:  Vaginal  Anal  Oral  None  Prefer not to answer

Method of Contraception: \_\_\_\_\_

Condom use:  Always  Usually  Sometimes  Never

Have you had any surgeries or pregnancies since you were here last?  Yes  No

Have you had any new medical diagnosis/conditions since you were last here?  Yes  No

**Social History**

Relationship status:  Single  Engaged  Married  Divorced  Widow Length of current relationship \_\_\_\_\_

Do you feel safe in your relationships?  Yes  No

Are you in a relationship where you are being physically, sexually, or emotionally hurt or threatened?  Yes  No

Are you afraid to return to where you are living?  Yes  No

Constitutional	Fever			
	Weight loss/weight gain			
	Night Sweats			
	Fatigue			
	Headaches			
Head/Ears/Nose/Throat	Decreased hearing			
	Hoarseness			
Breasts	Lumps			
	Tenderness			
	Nipple Discharge			
	Breast skin change			
	Swelling			
	Redness			
Heart	Chest pain			
	Irregular heart beats			
	Rapid heart rate			
	Fainting			
Lungs	Shortness of breath			
	Cough			
Gastrointestinal	Abdominal pain			
	Nausea			
	Vomiting			
	Diarrhea			
	Constipation			
	Heartburn			
	Blood in stools			

No Yes

Indicate if you have experienced any of the following symptoms in the past 2 weeks:

Kidney, Bladder	Painful urination			
	Urgency			
	Frequency			
	Incontinence			
	Blood in urine			
Genitals	Pelvic pain			
	Vaginal discharge			
	Painful periods			
	Painful intercourse			
Skin	Itch			
	New skin lesions			
	Muscular weakness			
	Tingling			
	Numbness			
Musculoskeletal	Muscle pain			
	Joint pain			
	Back pain			
Endocrine	Hot flashes			
	Loss of hair			
	Abnormal body hair			
Psychiatric	Anxiety			
	Depression			
	Memory loss			
	Mood changes			
Heme-Lymph	Easy bleeding			
	Easy bruising			

No Yes

Review of Systems:

What type of diet do you follow:  Standard American  Healthy  Vegetarian  Gluten free  Other

Do you use Tobacco now?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Type:	Daily amount:	How long?
Have you used Tobacco in the past?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Type:	Daily amount:	How long?
Do you use alcoholic beverages?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Type:	Weekly Amount:	How long?
Do you use recreational drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Type:	Weekly Amount:	How long?
Do you exercise?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Type:	How often?	How long?