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	❑	❑	❑	❑
Feeling down, depressed or helpless	❑	❑	❑	❑

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	Are periods painful?
_____	_____	_____	❑ Light	❑ Yes ❑ No
_____	_____	_____	❑ Average	Medication used:
			❑ Heavy	_____

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

(Please see reverse)

Do you use Tobacco now?	❑ Yes ❑ No	Type:	Daily amount:	How long?
Have you used Tobacco in the past?	❑ Yes ❑ No	Type:	Daily amount:	How long?
Do you use alcoholic beverages?	❑ Yes ❑ No	Type:	Weekly Amount:	How long?
Do you use recreational drugs?	❑ Yes ❑ No	Type:	Weekly Amount:	How long?
Do you exercise?	❑ Yes ❑ No	Type:	How often?	How long?

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

Review of Systems:

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

		No	Yes
Constitutional	Fever		
	Weight loss/weight gain		
	Night Sweats		
	Fatigue		
Head/Ears/Nose/Throat	Headaches		
	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
Kidney, Bladder	Painful urination		
	Urgency		
	Frequency		
	Incontinence		
	Blood in urine		
Genitals	Pelvic pain		
	Vaginal discharge		
	Painful periods		
	Painful intercourse		
Skin	Rash		
	New skin lesions		
Neurologic	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		

Patient Signature _____ **Date** _____

OB-GYN, P. C. Signature _____ **Date** _____

OB-GYN, P.C.
PATIENT HISTORY FORM Date _____ Dr. _____ / _____

Name _____ Date of Birth _____

Please choose whichever option best applies for race: ❑ Asian ❑ American Indian or Alaska Native ❑ African American ❑ Hawaiian Native
❑ Other Pacific Islander ❑ Caucasian ❑ More than one Race ❑ Unreported/Refuse to Report

Please check the box for whichever option best applies for Ethnicity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ Unreported/Refuse to Report

What is your main reason for today's visit? _____

What is your main symptom? _____

Gynecologic History

❑ Frequent Bladder Infections ❑ Gonorrhea ❑ Chlamydia ❑ Condyloma/HPV/Warts ❑ Genital Herpes ❑ Syphilis ❑ HIV/AIDS ❑ DES exposure
❑ HPV vaccine ❑ Trichomonas ❑ Abnormal Pap smear When: _____ Treatment: _____

Gynecologic Surgeries (Please indicate year)

❑ Hysterectomy _____ ❑ Ovaries Removed _____ ❑ Cesarean Section _____ ❑ Anterior/Posterior Repair _____ ❑ Dilation and Curettage (D&C) _____
❑ Tubal Ligation/Essure _____ ❑ Cryosurgery _____ ❑ LEEP _____ ❑ Cervical Conization _____

Pregnancy History

No.	Date (Mo./Yr.)	Weeks Gest.	Labor (Hrs.)	Spont.	Ind.	Type of Delivery	Alive/ Dead	Baby's Weight	Months Nursed	Sex	Complications (mom and baby)
1											
2											
3											
4											
5											
6											

General Health History

❑ Anemia
❑ Arthritis
❑ Asthma
❑ Back Trouble
❑ Blood Clot
❑ Cancer
Type: _____
❑ Diabetes
❑ Drug/Alcohol Abuse
❑ Glaucoma
❑ Heart Trouble
❑ High Blood Pressure
❑ Hepatitis
❑ Liver issues
❑ Kidney Disease
❑ Migraines With aura?
❑ Yes ❑ No
❑ Osteoporosis
❑ Osteopenia
❑ Rheumatic fever
❑ Thyroid Issues
❑ Blood Transfusion
❑ Tuberculosis
❑ Pneumonia
❑ Ulcer
❑ Vein Trouble
❑ Depression
❑ Anxiety
❑ Seizures
❑ Sepsis
❑ Stroke
❑ Major Trauma

General Surgery—Type and Date: _____

(Please see reverse)

Family History

	Age (if deceased: age at death and circle)	Good Health	Fair Health	Poor Health	Alcoholism	Blood Clotting Issues	Cancer	Colon Polyps	Diabetes	Heart Disease	High Blood Pressure	Kidney Disease	Mental Illness	Osteoporosis	Stroke	Thyroid Disease	Other	Comments
Father																		
Mother																		
Siblings																		

– please indicate Brother (B) or Sister (S)

Patient Signature _____ **Date** _____

OB-GYN, P.C. Signature _____ **Date** _____