

# Gynecological Patient History Annual Update

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_ Age: \_\_\_\_\_ Marital status: \_\_\_\_\_

ALLERGIES TO MEDICATIONS: \_\_\_\_\_

1. Have you had any tests (x-rays, lab work, etc.) since your last visit?  Yes  No

If yes, please specify: \_\_\_\_\_

2. Have you been hospitalized or had surgery since your last visit?  Yes  No

If yes, please specify: \_\_\_\_\_

3. Have there been any illnesses or deaths in your family since your last visit?  Yes  No

If yes, please specify illness and/or cause of death, and relationship to you: \_\_\_\_\_

\_\_\_\_\_

4. Have you started taking any new medications, or changed medications, since your last visit (prescription, over-the-counter or street drugs)?  Yes  No

If yes, please indicate the product(s) and the reason(s) you started or changed: \_\_\_\_\_

\_\_\_\_\_

5. Please list current medications: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

6. Have there been any changes in your diet or appetite?

If yes, please specify: \_\_\_\_\_

7. Below please indicate any changes in your medical status since your last visit:

- Weight gain or loss, fever, and fatigue
- Vision changes, contacts, or glasses
- Mouth, nose, ear or sinus problems
- Chronic cough, asthma, or wheezing
- Dizziness, seizures, or numbness
- Sexually transmitted disease
- Vaginal infections/discharge
- Abdominal pain, nausea, or vomiting
- Chest pain, shortness of breath, rapid heartbeat
- Hot flashes, night sweats, heat or cold intolerance
- Heavy menstrual cycles affecting quality of life
- Muscle weakness, pain, or restricted movement
- Sadness, crying easily, excessive irritability, or anxiety
- Bowel problems, diarrhea, constipation or blood in stools
- Skin rashes or ulcers, breast pain, breast discharge or mass
- Easy bruising, bleeding from gums, or swollen lymph nodes
- Loss of urine, urination frequently, painful urination, or blood in urine

8. Do you exercise regularly?  Yes  No

If yes, specify the activity and hours per week: \_\_\_\_\_

\_\_\_\_\_

9. Number of children: \_\_\_\_\_

10. Number of pregnancies: \_\_\_\_\_

11. Date of last pregnancy: \_\_\_\_\_

12. Date of first day of last period: \_\_\_\_\_

13. How many days between each period: \_\_\_\_\_

14. How many days do your periods last? \_\_\_\_\_

15. Do you suffer from cramps?  Yes  No

If yes, are they:  Mild  Moderate  Severe

16. Do you spot between periods?  Yes  No

\_\_\_\_\_

17. Has there been any change in the frequency of your sexual activity or sexual partner since your last visit?

Yes  No

If yes, explain: \_\_\_\_\_

18. Are you currently using birth control?  Yes  No

If yes, please specify: \_\_\_\_\_

Are you happy with it? \_\_\_\_\_

19. Are you currently trying to conceive a baby?  Yes  No

If yes, how long have you been trying: \_\_\_\_\_

\_\_\_\_\_

20. Indicate your consumption of the following since your last visit:

Alcohol-glasses per week: Wine \_\_\_ Beer \_\_\_ Cocktails \_\_\_

Caffeine (coffee, teas, soda) per day \_\_\_\_\_

Cigarettes packs per day \_\_\_\_\_

21. Since your last annual exam at this office, have you developed any new medical problems? \_\_\_\_\_

\_\_\_\_\_

22. Are you interested in a new form of contraception?

Yes  No