Update Annual History Form

Women's Care consultants

Date: _____ Name: _____ Date of Birth: _____

What name should we call you? _____ **Problems Today?** _____

Place of Employment: _____ Occupation: _____

Who is your doctor? **APPELBAUM PHILPOTT STREIFF REINING MEYER**

List of All Medication and Dose ☐ **None** (Not taking any prescription medication)

1. _____ **Dose:** _____
2. _____ _____
3. _____ _____
4.

Are you having any other problems?

Breast Head/Throat
Digestive Heart/Lung
Psychiatric Urinary
Neurologic/Muscular
Other: _____

List of Drug Allergies and Reaction (rash, etc.)

_____

_____

_____

Allergic to Latex? Yes No

Personal Medical History: Circle all that apply

Diabetes **High Blood Pressure**

Heart Disease (type: _____)

Asthma/COPD **Blood Clot Leg/Lungs**

Decrease blood clot ability

Any other problems _____

Would you prefer an assistant in the room during your exam?
YES NO
Doesn't Matter

Social History
Husband/Partner Name:
_____

Do you smoke No/Yes
How many alcoholic drinks in a week _____

Recreational Drugs No/Yes
Type:_____

GYN History

Last Menstrual Period: _____ Do you start every 28 days? **Yes** **No,** every _____ days
Menopause No/Yes

Last Pap Smear: _____ **Last Mammogram:** _____

Do you do breast exams No/Yes/Occasionally

Bone Density Year: _____ **Normal/Abnormal Treatment** _____

Are you in a sexual relationship now? No/Yes More than one Partner? No/Yes

Female partner? No/Yes

How are you preventing pregnancy? _____

Any new pregnancies or deliveries since last visit? _____

Any new surgeries since last visit: No/Yes (please list)

_____

_____

_____

_____

Any new family members diagnosed with cancer or serious illness and what type since last visit? No/Yes (please list)

_____

_____

_____