

ANNUAL GYNECOLOGICAL UPDATE

Name: _____ DOB: _____ Today's Date: _____

Welcome Back! Please take a few moments to fill out this form to help update our records.

Please list any new medical problems:

Please list any surgeries since your last visit:

Any new medical problems in your family?

Please list all medications you are now taking:

Please list any allergies you have:

Ht: _____

WT: _____

Temp: _____

BP: _____

Pulse: _____

POX: _____

Do you smoke? How much? Do you drink alcohol? How much per week?
Do you use street drugs? Are you safe at home?

Last Menstrual Period: _____

Please check any that may apply:

General: weight loss weight gain fever fatigue

HEENT: vision changes hearing loss sore throat

CV: chest pain/pressure irregular heart beat swelling of legs

Resp: shortness of breath chronic cough spitting of blood

GI: bloody stool nausea/indigestion/vomiting diarrhea

Urinary: frequency pain with urination loss of urine

MS: muscle pain joint pain swelling of joints(s)

Skin: Rash change in size/color/shape of a mole

Neuro/psych: Depression/crying spells worsening headache

Do you perform monthly self breast exams? When was your last mammogram?

When did you have your last cholesterol checked?

For those over 40, when did you have your last sigmoidoscopy/colonoscopy/stool checked for blood?