ANNUAL HEALTH UPDATE

It is important that we have up to date health information for you. We ask that with your annual examination or if it's been more than one year since your last visit that you take a few moments to update us on any changes in your health. Please fill in the blanks where appropriate.

Your Name:____**Date**:________________________

E-Mail Address:_______________________________________May we e-mail you ?: Yes No

Have there been changes in address/phone number? [ ] Y or [ ] N

_____________________City_______________State_______________Zip_________________

Phone:_______________________________Cell:_____________________________________

Had any changes to your insurance company? [ ] Yes or [ ] No

Name of Insurance Co:________________Policy #:______________Group#________________

When was your last period?____

Are you pregnant or could you be pregnant? [ ] Y or [ ] N

Have you been pregnant during the last year? [ ] Y or [ ] N **Nurse only (G F P A L)**

What is your present form of birth control?____

What is the name of your Primary Care Physician?_______________________________________

Have you seen your Primary Care Doctor this year? [ ] Y or [ ] N

Do you have any d**rug allergies**? [ ] Y or [ ] N

1)__________________2)_________________3)________________4)____________________

Current list of medications:

1)__________________________2)_________________________________3)_________________

4)__________________________5)_________________________________6)_________________

New Surgery History: Have you had any surgeries since your last visit? [ ] Y or [ ] N

Please list:1)______________________________2)____

New Gyn History:

Please describe your m**enstrual cycles**: Regular, Irregular, Absent, Frequency: every___days.

Flow: Light, Moderate or heavy, for ___ days. Associated symptoms?____________________

New Family History:

Any new Health Issues affecting your immediate family? [ ] Y or [ ] N

Please explain:____

New Sexual History:

Have the total lifetime number of sexual partners you've had since your last visit changed? [ ] Y or [ ] N, if so by how many_____.

New Social History:

Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Widowed [ ] Separated

Do you regular participate in any exercise program? [ ] Y or [ ] N

What kind of program?____

Do you smoke? [ ] Y or [ ] N How many per day?_____. Do you consume alcohol? [ ] Y or [ ] N

How much?________________. Do you take any illicit/street drugs?

[ ] Y or [ ] N if so explain:____

How much caffeine do you consume per day?____# of glasses/cups.

New Health Maintenance: Please indicate the month and year.

Pap Smear:____________**Mammogram:**______________**Bone Density:**___________

Colonoscopy:_____________**Stool for Blood:**_____________**Cholesterol:**__________

Thyroid Screen:______________________

Patient's Signature:____________________________________**Date:**____________________