Women's Health Care Specialists

ANNUAL HEALTH UPDATE FOR ESTABLISHED PATIENTS

Date _____

Name_____ Date of Birth _____ Age ____ Marital Status _____

Home Phone (____)_____ Cell (____)_____ Work (____)_____

Emergency Contact Name & Relationship_____ Phone (____)_____

Reason for Visit _____

Problems/Concerns _____

Date of Last Mammogram _____ Date of Last DEXA Scan _____

Medications *** New medications or changes since your last visit (include dosage):** ☐ **No changes since last visit**

MEDICATION	DOSE	FREQUENCY

* Allergies _____ **Latex Allergy?** ☐ **YES** ☐ **NO**

Obstetric History

# Pregnancies?_____	# Miscarriages?_____	#Terminations?_____	☐ Never Been Pregnant
# Full Term Deliveries? _____	# Preterm Deliveries? _____	# Living Children? _____	☐ Children are Adopted

Menstrual Cycle

* First day of your last period? _____ * Cycles are ☐ Regular ☐ Irregular

***** If you no longer have menstrual cycles, check the reason below and enter the year your cycles stopped:***

☐ Post Menopausal Year_____ ☐ Hysterectomy Year _____ ☐ Do you use HRT? ☐ Yes ☐ No

Current Contraceptive Method (s) Check all the apply:

☐ None	☐ Diaphragm	☐ Partner Vasectomy	☐ Female Partner	IUD ☐ Mirena
☐ Condoms	☐ Natural Family Planning	☐ Tubal Ligation	☐ Implanon/Nexplanon Device	☐ Skyla
☐ Birth Control Pills List Brand _____		☐ Depo Provera	☐ Other _____	☐ Paragard

Family Medical History Check if any blood relatives have/had the following cancers: ☐ No changes since last visit

☐ Breast	☐ Ovarian	☐ Uterine	☐ Colon	Other (please list) _____

Personal Health History Changes ☐ No changes since last visit

* Please list any recent surgeries you have had: _____

* Please list any newly diagnosed health problems and/or injuries since your last visit: _____

Social History

* Do you smoke? □ NO □ YES Packs Per Day □ Do you drink alcohol? □ NO □ YES Drinks Per Week_____
* Do you exercise? □ NO □ YES Type _____ Days Per Week _____