ANNUAL UPDATE FORM

DATE: _______/_______/_______ **AGE:** ____________________

NAME: ____ **BIRTH DATE:** _______ /______/_______

When was the first day of you last menstrual period or year of menopause?__________________________

Since your last visit, have you had changes to any of the following:

Address or Phone numbers or Insurance Coverage: ____

Allergies : ____

Medications (type and dosages): ____

Gyn Issues (infections, pregnancies, etc …): ____

Medical Problems/ Surgeries/ Hospitalizations : ____

Family History: ____

New Social history, Life Events, Interests : ____

Do you currently smoke, drink alcohol or use drugs? (If yes, how much and how often?) ☐ **No** ☐ **Yes**

Is there anything you want to talk to you physician about?

RECENT PERSONAL HISTORY

Have you been recently hurt or threatened emotionally or physically?	☐ **No**	☐ **Yes**
Has anyone, including your partner, recently forced you to have sex?	☐ **No**	☐ **Yes**
Are you afraid of your partner?	☐ **No**	☐ **Yes**

REVIEW OF SYSTEMS

1. CONSTITUTIONAL		NOTES	7. GENITOURINARY		NOTES
Fever	☐		Abnormal Bleeding	☐	
Chills	☐		Vaginal discharge/ odor	☐	
Fatigue	☐		Vaginal itching/ burning	☐	
Weight Loss	☐		Pelvic pain	☐	
Weight gain	☐		Menstrual cramps	☐	
2. EYES			Painful intercourse	☐	
Changes in vision	☐		Genital lump	☐	
Double vision	☐		Fertility concerns	☐	
3. ENT/ MOUTH			Menopausal concerns	☐	
Ear aches	☐		8. MUSCULOSKELETAL		
Ringing in the ears	☐		Muscle weakness	☐	
Sinus problems	☐		Joint stiffness	☐	
Sore throat	☐		Joint pain	☐	
Mouth sores	☐		Joint swelling	☐	
Dry Mouth	☐		9. SKIN/ BREAST		
4. CARDIOVASCULAR			Breast pain	☐	
Chest pain	☐		Nipple discharge	☐	
Difficulty breathing on exertion	☐		Breast lumps	☐	
Swelling of legs	☐		Rash	☐	
Palpitations	☐		Ulcers	☐	
Heart Murmurs	☐		11. PSYCHIATRIC		
5. RESPIRATORY			Depression	☐	
Wheezing	☐		Mood swings	☐	
Spitting up blood	☐		Anxiety	☐	
Shortness of breath	☐		Suicidal thoughts	☐	
Cough	☐		Homicidal thoughts	☐	
6. GASTROINTESTINAL			12. ENDOCRINE		
Diarrhea	☐		Abnormal thirst	☐	
Constipation	☐		Hot flashes	☐	
Nausea/vomiting	☐		Tremors	☐	
Bloody stool	☐		Cold/ heat intolerance	☐	
Abdominal pain	☐		13. HEMATOLOGIC		
Indigestion	☐		Frequent bruising	☐	
Bloating	☐		Cuts do not stop bleeding	☐	
Liver problem/Hepatitis	☐		Enlarged lymph nodes	☐	
7. GENITOURINARY					
Blood in urine	☐				
Pain with urination	☐				
Urgency	☐				
Urinary Frequency	☐				
Urinary Incontinence	☐				

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