

Annual Office Visit

Name:

Date of Birth:

Current Medications (include hormones, herbs, vitamins, nonprescription medicine)

| Name and Dosage | Name and Dosage |
|-----------------|-----------------|
| 1. | 5. |
| 2. | 6. |
| 3. | 7. |
| 4. | 8. |

Allergies (Please include all drug allergies)

| | |
|----|----|
| 1. | 4. |
| 2. | 5. |
| 3. | 6. |

Major Health Problems Please answer each category

| | | | | | | |
|------------------|------|------------------------------------|--------------------------|---------------------------------------|--------------------------------------|--------------------|
| General | None | Fever | Chills | Sweats | Loss of Appetite | Fatigue |
| | | Generally feel badly | Weight loss | | | |
| ENT | None | Earache | Hoarseness | Ringling In ears | Decreased hearing | |
| | | Nasal congestion | Nosebleeds | Sore throat | Difficulty swallowing | |
| Heart | None | Chest pains | Palpitations | Fainting Spells | Difficulty breathing when lying flat | |
| | | Out of breath exertion | Short of breath at night | | Swelling in legs | |
| Lung | None | Cough | Shortness of breath | | Excessive sputum | |
| Gastro | None | Nausea | Vomiting | Diarrhea | Constipation | |
| | | Change in bowel habits | Abdominal pain | Black/tarry Stools | Jaundice | Vomiting blood |
| Urinary | None | Leaking urine with cough or sneeze | | Leaking urine without cough or sneeze | | |
| | | Burning with urination | | Blood in urine | Urinary frequency | |
| Breasts | None | Pain | Lump | Discharge | | |
| GYN | None | Vaginal discharge with itching | | Vaginal discharge with odor | | |
| | | Other vaginal discharge | | Pelvic pain | Abnormal vaginal bleeding | |
| | | Heavy vaginal bleeding | | Missed periods | Irregular menses | |
| Ortho | None | Back pain | Joint swelling | Muscle cramps | | |
| | | Muscle weakness | Stiffness | Arthritis | | |
| Skin | None | Rash | Itching | Dryness | | |
| Neuro | None | Sensation of room spinning | | Weakness | Tingling | Seizures |
| | | Fainting spells | | Tremors | | |
| Psych | None | Depression | | Anxiety | Memory loss | Mental disturbance |
| | | Suicidal thoughts | | Hallucinations | | |
| Endocrine | None | Cold intolerance | | Heat intolerance | | Excessive thirst |
| | | Excessive hunger | | Excessive amounts of urine | | |
| | | Significant weight loss | | Significant weight gain | | |

Since Your Last Visit:

| | Please Describe |
|--|-----------------|
| Have you been diagnosed with a new medical problem ? | |
| Have you had any surgeries? | |
| Have you been diagnosed with a new medication allergy? | |
| Do you have any new family history? | |

| Annual Care | | | | Yes | No | | | | |
|--|--|-----------------|----------------|-----------------|----------------------|-------------|--------------|------------|----------|
| Do you examine your breasts? | | | | | | | | | |
| Do you get 1200 – 1500 mg of calcium daily? | | | | | | | | | |
| Caffeine use- how many drinks per day? | | | | | | | | | |
| Have you seen your PCP in the last year? | | | | | | | | | |
| Did they do lab work? | | | | | | | | | |
| What year was your last Mammogram? | | Bone Density? | | Colonoscopy? | | | | | |
| Menstrual History | | | | Yes | No | | | | |
| Are you menopausal? | | | | | | | | | |
| Have you had a hysterectomy? | | | | | | | | | |
| Are you currently late for your period? | | | | | | | | | |
| Are you currently pregnant? | | | | | | | | | |
| What was your age at your first menstrual period? | | | | | | | | | |
| Date of your last menstrual period: | | | | | | | | | |
| Are your periods regular (28-30 days)? | | | | | | | | | |
| If No what is the interval between your periods? (Number of days) | | | | | | | | | |
| How many days of bleeding do you have? | | | | | | | | | |
| How many heavy days? | | | | | | | | | |
| Do you have pain with your period? | | | | | | | | | |
| If Yes- how bad is that pain? | | Minimal | Mild | Moderate | Severe | | | | |
| Do you have a problem with heavy bleeding? | | | | | | | | | |
| Do you bleed onto your clothes or bedding? | | | | | | | | | |
| Do you bleed after intercourse? | | | | | | | | | |
| Do you have bleeding between your periods? | | | | | | | | | |
| If Yes- how bad is that bleeding? | | Light | Medium | Heavy | | | | | |
| Occurring? | | Early | Mid-cycle | Late | Just prior to menses | Random | | | |
| Contraception | | | | Yes | No | | | | |
| Are you in a sexual relationship? | | | | | | | | | |
| Do you have pain with intercourse? | | | | | | | | | |
| Are you trying to become pregnant? | | | | | | | | | |
| Do you have questions about sexual function, contraception, or infections? | | | | | | | | | |
| Permanent Sterilization Method: | | Essure | Tubal ligation | Vasectomy | Hysterectomy | None | | | |
| What type of contraception do you currently use? | | None | Essure | Tubal ligation | Hysterectomy | | | | |
| | | Abstinence | Rhythm Method | Male withdrawal | Condoms | Spermicides | Diaphragm | | |
| | | Norplant | Pills | Patch | Ring | Shot | IUD-Paragard | IUD-Mirena | Implanon |
| What type of contraception have you previously used? | | None | Abstinence | Rhythm Method | | | | | |
| | | Male withdrawal | Condoms | Spermicides | Diaphragm | Norplant | Pills | Patch | |
| | | Ring | Shot | IUD-Paragard | IUD-Mirena | Implanon | | | |