



OPTIMUM WOMEN'S CARE

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HISTORY UPDATE				
Patient Name				Date
Thank you for taking the time to answer these questions. Most insurance companies require this information to be updated at <b>every</b> visit. Please <b>CIRCLE</b> any symptoms which you are currently experiencing.				
<b>Constitutional</b>	<b>Gastrointestinal</b>	<b>Skin/Hair</b>	<b>Breast</b>	<b>Head, Ears, Nose, Throat</b>
Fatigue	Nausea/Vomiting	Rash	Breast Lumps	Headache
Weight Loss	Diarrhea	Skin Lesions	Breast Tenderness	Sore Throat
Weight Gain			Nipple Discharge	
<b>Neurologic</b>	<b>Cardiovascular</b>	<b>Musculoskeletal</b>	<b>Respiratory</b>	<b>Endocrine</b>
Seizures	Chest Pain	Joint Pain	Cough	Hair Loss
Tingling	Irregular Heartbeat	Joint Swelling	Wheezing	Temperature Intolerance
Numbness			Shortness of Breath	Abdominal Hair Growth
When was your last menstrual period?				
Have you had any serious illnesses, operations or hospitalizations since your last visit?				
Have you discovered any additional information about your family history that we should know?				
Have you changed any habits (smoking, drinking, etc.) or occupation since your last visit?				
Please list all current medications and doses including herbals and vitamins.				
Please list any current allergies.				
Please briefly describe the reason for your visit today.				

Thank you.