My OB/GYN
"Women Specialists For Women"

BOARD CERTIFIED OBSTETRICS & GYNECOLOGY

Helen Salsbury, M.D, FACOG
Selena Hodgers, ARNP – BC

PATIENT'S ANNUAL HISTORY UPDATE - pg 1

Date of Appointment: _____

Name: _____ **Date of Birth:** _____

Current Insurance on file: _____ **Policy#** _____

Allergies _____ **Marital Status** _____ **Partner** _____

Primary Physician: _____ **Phone:** _____ **Fax:** _____

Total Times Pregnant _____ Total Births _____ Total Premature Births (<37 weeks) _____ Total Living Children _____

When was the first day of your last period? _____ Days long? _____

Sexually Active? ☐ Y ☐ N Current Birth Control? _____

How many days are in between your menstrual periods? _____ Menstrual flow is ☐ Heavy ☐ Moderate ☐ Light

Tobacco Use ☐ None ☐ Current - Packs/Day _____

Alcohol Use: ☐ None ☐ Social/Holiday ☐ Weekly, specify _____ ☐ Daily, specify _____

Please (✔) if you have experienced any of the following symptoms in the last 3 months

✓	Symptom	Notes	✓	Symptom	Notes
	Weight Loss/Gain			Breast pain / Lumps	
	Headaches			Breast discharge	
	Change - Memory			Genital sores	
	Change - Sleep habits			Abnormal periods	
	Change - vision, hearing			Painful periods	
	Change - Skin			Post-menopausal bleed	
	Change - Appetite			Intercourse pain / bleed	
	Change - Breathing			Vaginal discharge	
	Change - Bowel Habits			Hot flashes	
	Change - Urine Habits			Joint pain	
	Chest pain / Palpitations			Mood swings	
	Swelling of Legs			Vaginal dryness	
	Dental Problems			Vaginal itch	
	Excessive thirst			Fatigue / Weakness	
	Gut related issues			Depression / Anxiety	

Other Symptoms

List current medication (including over the counter or vitamins)

Describe your exercise and diet routines

HEALTH SCREENING TOOL	Mark (✓) n/a, need or had for each line item	n/a	Need	Had
Colonoscopy	Over 50; family/personal history of inflammatory bowel, colon cance, colon polyps			
Bone Density	Over 65 or family history of osteoporosis; post-menopausal; on steroid drugs; lack exercise; celiac			
Hemoglobin	Heavy bleeding, Caribbean, Latin American, Asian, Mediterranean, African decent			
Thyroid Stim Hormone	Strong family history of thyroid disease / personal history of autoimmune disease			
Lipid Panel	Smoker; post-menopausal; diabetic; close relative with elevated cholesterol / cardiac disease			
Fasting Glucose	Family history of diabetes; obese; developed diabetes in pregnancy (do every 3-5 yrs)			

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PATIENT'S ANNUAL HISTORY UPDATE - pg 2

Since your last annual exam, list changes to your medical history (illnesses, operations, injuries, hospitalization, pregnancies)

Since your last annual exam, list any changes to your family history

When was your last Dental Exam _____

Recent Blood Work Results _____

Have you been treated for any of the following infections in the last year?

Bacterial Vaginosis	☐ Y	☐ N	_____	Gonorrhea	☐ Y	☐ N	_____
Urinary Tract Infections	☐ Y	☐ N	_____	Chlamydia	☐ Y	☐ N	_____
Herpes	☐ Y	☐ N	_____	Trichomoniasis	☐ Y	☐ N	_____
Genital Warts	☐ Y	☐ N	_____	Syphilis	☐ Y	☐ N	_____

RECENT VACCINATIONS

Last Flu Shot _____ Last Tdap _____ Last Pnuemonia _____

SAFETY

1) Have you been hit, kicked, punched, or otherwise hurt by someone in the past year? Y N _____
2) Do you feel safe in your current relationship? Y N _____
3) Is there a partner from a previous relationship who is making you feel unsafe now? Y N _____

FOR MEDICARE PATIENTS, PLEASE ANSWER THE FOLLOWING

1) Pap smear in the last 7 years? N Y _____
2) Abnormal Pap smear? N Y when? _____
3) Ever tested positive for the HIV virus? N Y _____
4) Sexual activity before 16 years old? N Y _____
5) More than 5 sexual partners in lifetime? N Y _____
6) Mother take DES when pregnant with you? N Y _____

COMPLETED BY:

_____ _____
PATIENT SIGNATURE FORM COMPLETE DATE

REVIEWED BY:

_____ _____
PROVIDER SIGNATURE DATE