Arbor Obstetrics and Gynecology
Annual Health and Wellness Update

We are pleased to see you for annual exam. Having an annual exam is an excellent way of making sure you are up to date on all necessary tests and exams. It is also a good time to review your lifestyle and health habits to make sure you are doing everything possible to ensure that you will remain free of injury and disease. The following questionnaire is detailed, but it has been carefully written to help us identify those things in your life that are most likely to impact your life. We appreciate you taking the time to fill it out accurately and completely.

Name: _____Today's Date: _____
Date of last menstrual period: _____Date of last annual exam _____

Who is your primary care doctor (please give name and office number if known)?
_____

Have you had any changes in your health or medical history since your last yearly exam with us? (For example: newly diagnosed with diabetes, high blood pressure or other)
_____
_____
_____

What medications do you take? Please list names and dosages of all current medications, including birth control (even if they are not different from last year).
_____ _____
_____ _____
_____ _____

Have you had any new surgeries, procedures or been hospitalized for any reason since your last annual exam?
_____
_____

Do you have regular menstrual cycles? _____
Are you having any problems with your menstrual cycles? _____

Are you sexually active? _____
(If applicable please answer the following questions)
Are you with a new partner since last year? _____
If yes, how many partners have you had in the last year? _____
If you are not in a long term monogamous relationship do you always use a condom and practice safe sex? _____
Would you like to be tested for sexually transmitted diseases? _____

(Continued on the next/reverse page)

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Have there been any social changes in your life since your last yearly exam? (Such as marriage, divorce, new child, loss of parent or loved one, new job, etc.)

_____
_____

Are you generally happy with your work or school and social/ family situations?

_____

Do you use tobacco? _____ Do you use any recreational drugs? _____
If you drink alcohol, how many drinks do you generally drink per week? _____

Do you regularly have any of the following symptoms? (Please circle)

Recurrent fevers/ persistently swollen glands/ skin rashes/ sores on the skin/ chronic itching/ severe headaches/ episodes of fainting/ seizures/ numbness or muscle weakness/ cough/ shortness of breath/ wheezing/ chest pain/ swelling of the legs/ hot or cold intolerance/ significant weight change/ abnormal hair growth/ excessive thirst/ abnormally frequent urination/ blood in the urine/ abnormal bruising or bleeding/ severe mood swings/ depression/ anxiety/ joint pain or swelling/ difficulty moving any joints/ pain with intercourse/ pain with menstrual cycles/ vaginal discharge or odor/ sores in the genital area/ leaking of urine/ hot flashes/ vaginal dryness

Has anyone in your family been diagnosed with new health problems since your last visit?

_____

Do you do the following?

Self breast exam at least once a month? _____
Wear a seatbelt in the car at all times? _____
Engage in aerobic exercise at least 3 times per week? _____
Take a calcium supplement every day? _____
Take folic acid or multivitamin with folic acid in it every day? _____
Sunbathe or use a tanning bed? _____
Generally eat a healthy diet? _____
See a dentist or hygienist and an eye doctor at least annually? _____

Are you exposed to violence of any type (physical or emotional)? _____

Are there any issues or concerns which you would like to discuss that have not been addressed in the questionnaire?

_____
_____