



Update Form

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Doctor: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Ethnicity: \_\_\_\_\_ 1<sup>st</sup> day of your last menstrual period: \_\_\_\_\_

Why do you need to be seen? \_\_\_\_\_

(Please check all that apply to you **now**)

<b>HENT</b>	<b>Yes</b>	<b>Gynecological</b>	<b>Yes</b>
Headaches		Vaginal discharge/irritation/odor	
Sore throat		Irregular bleeding	
<b>Breasts</b>		Painful periods	
Breast lumps		Painful intercourse	
Nipple discharge		Pelvic Pain	
Breast pain		<b>Skin</b>	
<b>Cardiovascular</b>		Genital sores/bumps	
Chest Pain		Unexplained lumps	
Heart Palpitation		Acne	
<b>Respiratory</b>		<b>Musculoskeletal</b>	
Wheezing		Back Pain	
Cough		Joint Pain	
Shortness of breath		<b>Endocrine</b>	
<b>Gastrointestinal</b>		Weight loss	
Abdominal pain		Weight gain	
Nausea		<b>Psychological</b>	
Vomiting		Anxiety	
Constipation		Depression	
Diarrhea		Difficulty sleeping	
Blood in stool		Panic attacks	
Change in bowel habits		<b>HEME/Lymph</b>	
<b>Genitourinary</b>		Easy bruising	
Painful urination		Easy Bleeding	
Leaking urine		<b>Allergic/Immunological</b>	
Urinary urgency		Hay Fever	
Urinary frequency		Sinus congestion	
Blood in urine		<b>Constitutional</b>	
Nocturia (urinating 2 or more times/night)		Fatigue	
		Fever	
		Chills	

CURRENT MEDICATIONS (prescription, over the counter, vitamins, birth control, herbs etc)

Name	Dosage (mg)	Frequency	Date Started	Prescribing MD

ALLERGIES (drugs, foods, latex)

REACTION


Any changes in your period: \_\_\_\_\_

Do you have sexual intercourse?  Yes  No

If yes, how do you prevent pregnancy? \_\_\_\_\_

If yes, do you have/have you had a new sexual partner since your last exam? :  Yes  No

Medical Problems (changes since last visit): \_\_\_\_\_

\_\_\_\_\_

Surgeries (changes since last visit, include surgeon's name and date): \_\_\_\_\_

\_\_\_\_\_

Major Changes in your life: \_\_\_\_\_

\_\_\_\_\_

Tobacco/Cigarettes Use:  Never  Quit (date)\_\_\_\_\_

Current smoker \_\_\_\_packs/day, X \_\_\_\_ yrs

Alcohol Use:  Yes  No

\_\_\_\_\_ drinks per week ""(  ""beer  ""wine  ""liquor)

Is alcohol use a concern for you or others?"  ""Yes  ""No

Drug Use:  Yes  No

If so, what drug(s)\_\_\_\_\_

Exercise: Do you exercise regularlyA""  Yes  No

If no, why not? \_\_\_\_\_

If yes, what kind of exercise\_\_\_\_\_

How often? \_\_\_\_\_ ""How long? \_\_\_\_\_

Diet: How do you rate your current diet?  Good  Fair  Poor

Changes to health of a family member: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_