WOMEN PARTNERS
IN OB/GYN

UPDATE FORM

Name: _____ Date: _____ Doctor: _____

Date of Birth: _____ Ethnicity: _____ 1st day of your last menstrual period: _____

Why are you seeing the doctor/nurse practitioner today? _____

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

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

(continued on back)

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: ◯ No ◯ Yes

_____ drinks per week (☐beer ☐wine ☐liquor)

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

Drug Use: ◯ No ◯ Yes

If so, what drug(s)_____

Exercise: Do you exercise regularly ◯ 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: _____

_____

_____