Women Partners
in OB/GYN

Annual Wellness Visit Update Form

Name: _____ Date: _____ Doctor: _____

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

REVIEW OF SYSTEMS: (Please check all that apply to you **TODAY**)

	Yes		Yes
Constitutional		**Genitourinary**	
Headache		Painful urination	
Fatigue		Leaking urine	
Fever/chills		Urinary urgency	
Weight gain		Urinary frequency	
Weight loss		Blood in urine	
		Urinating 2 or more times/night	
Cardiovascular			
Chest pain		**Gynecological**	
Heart palpitation		Vaginal discharge	
		Vaginal irritation/itching	
Respiratory		Vaginal odor	
Cold/allergy symptoms		Vaginal dryness	
Wheezing/cough		Irregular bleeding	
Shortness of breath		Painful periods	
		Painful sex	
Breast		Pelvic pain	
Breast lumps		Genital sores/bumps	
Nipple discharge		Sexual function concerns	
Breast pain			
		Peri/menopause symptoms	
Musculoskeletal		Hot flashes	
Back Pain		Night sweats	
Joint Pain		Difficulty sleeping	
		Decreased libido	
Skin		Mood changes	
Rash/sores/bumps		Brain fog	
Acne			
		Psychological	
Gastrointestinal		Anxiety	
Abdominal pain		Depression	
Nausea		Difficulty sleeping	
Vomiting		Panic attacks	
Constipation			
Diarrhea		**Other:**	
Blood in stool			
Change in bowel habits			

*Please be aware that an annual wellness exam is a preventative screening visit and addressing multiple problems at this time may result in the need for another appointment to discuss in detail.

(Continued on back)

GYNECOLOGICAL UPDATES

Do you have sex? ☐ Yes ☐ No

If yes, do you have sex with: ☐Men ☐ Women ☐Both

Have you had a new sexual partner since your last exam? : ☐Yes ☐No

How do you prevent pregnancy? _____

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

Name	Dosage (mg)	Frequency	Date Started	Prescribing MD

ALLERGIES(drugs, foods, latex) REACTION

PREVENTATIVE HEALTH

	Date/results/location
Primary Care Visit	
Wellness labs	
Abnormal results?	
Mammogram	
Colonoscopy (45 and up)	
Bone density scan (menopause)	

Medical/Surgical/Family History updates since last visit:_____

_____

_____

Social History updates since last visit (marital status, job, school, family, stressors etc): _____

_____

_____

Abuse Screen ☐None ☐Physical abuse ☐Sexual abuse ☐Emotional abuse

Tobacco/Cigarettes Use: ☐Never ☐Quit (date)_____ ☐ Current, ____packs/day, X ____yrs

Alcohol Use: ☐No ☐Yes, # _____ drinks per week (☐beer ☐wine ☐liquor)

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

Drug Use: ☐No ☐Yes, If so, what drug(s)_____

Exercise: Do you exercise regularly? ☐No ☐Yes

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