Annual Office Visit

Name: Date of Birth:

Current Medications (include hormones, herbs, vitamins, nonprescription medicine)	
Name and Dosage	**Name and Dosage**
1.	5
2.	6.
3.	7.
4.	8.

Allergies (Please include all drug allergies)	
1.	4.
2.	5.
3.	6.

Major Health Problems
Please answer each category

General	None	Fever	Chills	Sweats	Loss of Appetite	Fatigue
		Generally feel badly	Weight loss			
ENT	None	Earache	Hoarseness	Ringing In ears	Decreased hearing	
		Nasal congestion	Nosebleeds	Sore throat	Difficulty swallowing	
Heart	None	Chest pains	Palpitations	Fainting Spells	Difficulty breathing when lying flat	
		Out of breath exertion	Short of breath at night		Swelling in legs	
Lung	None	Cough	Shortness of breath		Excessive sputum	
Gastro	None	Nausea	Vomiting	Diarrhea	Constipation	
		Change in bowel habits	Abdominal pain	Black/tarry Stools	Jaundice	Vomiting blood
Urinary	None	Leaking urine with cough or sneeze		Leaking urine without cough or sneeze		
		Burning with urination	Blood in urine	Urinary frequency		
Breasts	None	Pain	Lump	Discharge		
GYN	None	Vaginal discharge with itching		Vaginal discharge with odor		
		Other vaginal discharge	Pelvic pain	Abnormal vaginal bleeding		
		Heavy vaginal bleeding	Missed periods	Irregular menses		
Ortho	None	Back pain	Joint swelling	Muscle cramps		
		Muscle weakness	Stiffness	Arthritis		
Skin	None	Rash Itching	Dryness			
Neuro	None	Sensation of room spinning	Weakness	Tingling	Seizures	
		Fainting spells	Tremors			
Psych	None	Depression	Anxiety	Memory loss	Mental disturbance	
		Suicidal thoughts	Hallucinations			
Endocrine	None	Cold intolerance	Heat intolerance	Excessive thirst		
		Excessive hunger	Excessive amounts of urine			
		Significant weight loss	Significant weight gain			

Since Your Last Visit:

	Please Describe
Have you been diagnosed with a new medical problem ?	
Have you had any surgeries?	
Have you been diagnosed with a new medication allergy?	
Do you have any new family history?	

Annual Care	Yes	No
Do you examine your breasts?		
Do you get 1200 – 1500 mg of calcium daily?		
Caffeine use- how many drinks per day?		
Have you seen your PCP in the last year?		
Did they do lab work?		
What year was your last Mammogram? / Bone Density? / Colonoscopy?		

Menstrual History	Yes	No
Are you menopausal?		
Have you had a hysterectomy?		
Are you currently late for your period?		
Are you currently pregnant?		
What was your age at your first menstrual period?		
Date of your last menstrual period:		
Are your periods regular (28-30 days)?		
If No what is the interval between your periods? (Number of days)		
How many days of bleeding do you have?		
How many heavy days?		
Do you have pain with your period?		
If Yes- how bad is that pain? Minimal Mild Moderate Severe		
Do you have a problem with heavy bleeding?		
Do you bleed onto your clothes or bedding?		
Do you bleed after intercourse?		
Do you have bleeding between your periods?		
If Yes- how bad is that bleeding? Light Medium Heavy		
Occurring? Early Mid-cycle Late Just prior to menses Random		

Contraception	Yes	No
Are you in a sexual relationship?		
Do you have pain with intercourse?		
Are you trying to become pregnant?		
Do you have questions about sexual function, contraception, or infections?		
Permanent Sterilization Method: Essure Tubal ligation Vasectomy Hysterectomy None		
What type of contraception do you currently use None Essure Tubal ligation Hysterectomy		
Abstinence Rhythm Method Male withdrawal Condoms Spermicides Diaphragm		

	Norplant	Pills	Patch	Ring	Shot	IUD-Paragard	IUD-Mirena	Implanon
What type of contraception have you previously used?						None	Abstinence	Rhythm Method
	Male withdrawal	Condoms	Spermicides	Diaphragm	Norplant	Pills	Patch	
	Ring	Shot	IUD-Paragard	IUD-Mirena	Implanon			