ANNUAL

OB/GYN associates

Medical History UPDATE Form

Name: _____ Today's Date: _____

Birthdate: _____ Age: _____

Primary Care Physician: _____ Preferred Lab: _____

Preferred Pharmacy: _____ Preferred Imaging Center: _____

Reason for Visit: Please check

❑ Annual - Well Woman Exam Check Up

❑ Problem - Please List: _____

1st Day of Most Recent Period: _____ Number of Pregnancies: _____ Number of Births: _____

Current Contraception: (Please indicate)

❑abstinence ❑withdrawal ❑rhythm ❑condoms ❑foam/spermicides ❑pills

❑patch ❑ring ❑Depo-Provera ❑implant ❑tubes tied/plugged ❑IUD

❑vasectomy ❑hysterectomy ❑infertility ❑menopause ❑same gender sexual partner ❑none

Health Maintenance and Modifiers: Please list dates of last test or treatment

Pap Smear: _____ Colonoscopy: _____

Mammogram: _____ Cholesterol/Lipid Screen: _____

Bone Density: _____ Gardasil/HPV vaccine: _____

Exercise: ❑none ❑irregular ❑regular ❑aerobic ❑weight bearing

Calcium: ❑none ❑ milk/dairy ❑dietary ❑supplements

Sexual Activity:

Are you currently in a sexual relationship?	❑Yes	❑No	
New sexual partner in last year?	❑Yes	❑No	
Current sexual partner	❑Male	❑Female	
Prevention of Sexually Transmitted Infection:	❑Abstinence	❑Condoms	❑ Monogamy
Do you want testing for STIs:	❑Yes	❑No	

NEW Medical and Surgical Updates: Please list any changes since your last visit (heart disease, diabetes, surgeries, etc)

Date	Type of Surgery / New Medical Condition

NEW Family Medical Conditions: List Family Member (parent, grandparent, sibling, aunt, uncle, children)

Blood clotting disorders, cancers, heart disease, etc _____

Allergies: (to medications, latex, iodine, shellfish, or nuts)

Allergy	Reaction Type

OB/GYN associates

Current Medications or Supplements: (Name, dose and prescribing doctor)

Medication Name	Dosage	Frequency	Prescribing Doctor

Supplements: Supplements, Vitamins, etc

Supplement	Reason for use

Social:

Your Occupation: _____

Your Employer: _____

Marital Status: single engaged domestic partner married separated divorced widowed

Name of spouse/partner: _____

Alcohol: Average number of drinks_____/day or_____/week or none

Tobacco: Do you smoke?: ❑Yes ❑No ❑Past
If yes, how many cigarettes per day?_____for how long? _____

Recreational Drug Use: ❑Yes ❑No ❑Past

Patient Signature / Date: _____