Rhett Women's Center Medical History Update Form G___P___ A___

(Office Use)

Patient Name_____**DOB**_____ **Date**_____
Home Phone_____**Cell Phone**_____**Work Phone**_____
E-mail _____Ok to e-mail test results ___Yes ___No
Reason for today's visit: ____ Annual ____Problem____Follow-up ____Other
Brief description of problem or other concern: _____

Personal Health History:
When was your last menstrual period? _____
Was your last period normal? ___Yes ___No
Current method of birth control:_____
Have you had any changes in your period since last visit? _____
Have you had any surgeries / hospitalizations since your last visit? _____
Have you had any new medical diagnosis since your last visit? _____

Please check all that apply to yourself:
Breast Cancer_____ Cervical Cancer_____ Thyroid Problems_____
Uterine Cancer_____ High Blood Pressure_____Other Cancers Not Mentioned_____
Ovarian Cancer_____ High Cholesterol_____ Other Diseases Not Mentioned_____

Surgical History: Please list All Surgeries: _____
_____
_____

Family History: Please check all that apply to Mother/Father/Grandparents/Sister/Brother
Cervical Cancer____ Uterine Cancer_____ High Cholesterol_____
Colon Cancer_____ Ovarian cancer_____ Other diseases not mentioned_____
Breast Cancer_____ High Blood Pressure_____Other Cancers not mentioned_____

Social History:
Employment: _____ Marital Status_____
Is violence at home a concern for you? __Yes __No
Do you use tobacco? __Yes __No. If yes how many packs per day? _____
Do you drink alcohol? __Yes __No. If yes how much per week? _____
Do you use drugs? __Yes __No
Are you sexually active? __Yes __No __Not currently __Never been sexually active.
Have you had four or more sexual partners? __Yes __No
Have you had any sexually transmitted diseases? __**Yes** __No
Have you ever been abused? __Yes __No
Have you had a weight change? __Gained __ Loss. How many pounds? _____
Do you exercise 3 or more times a week? __Yes __No

Please List Current Medications: _____
_____
_____

Please List Allergies: (Medication and Food) _____
_____
_____

Name_____Date_____

Review of Symptoms: Please check any current problems you have on the list below:

General
___Fever
___Chills
___Fatigue
___Weight Loss

Skin
___Rash
___Sweaty
___Itchy

Gastrointestinal
___Abdominal Pain
___Constipation
___Diarrhea
___Nausea
___Vomiting

Neurological
___Seizures
___Dizziness
___Syncope
___Weakness
___Numbness

Ear/Nose/Throat
___Hearing Loss
___Nosebleeds
___Sore Throat
___Rhinitis

Cardiac
___Chest Pain
___Palpitation
___Orthopnea
___DOE

Endocrine
___Heat/Cold Intolerance
___Thirsty
___Polyuria

Hematology
___Easy Bleeding
___Easy Bruising

Eyes
___Blurred
___Diplopia
___Photophbia

Respiratory
___Cough
___SOB
___Hemoptysis

Muscular Skeletal
___Back Pain
___Joint pain
___Myalgia

Psychiatric
___Anxiety
___Depression
___Suicide

Urinary
___Dysuria
___Incontinence
___Incmp Voiding
___Urgency
___Discharge
___Flank Pain
___Frequency
___Straining
___Hematuria
___Weak Stream
___Hesitancy

Night Sweats
___Never ___1-3 times a week ___Nightly

Sleeping problems
___Never ___1-3 times a week ___Nightly

Hot Flashes / hot flushes
___Never ___1-3 times a week ___Daily / Nightly

Sexual drive
___Never ___Decreased ___No Desire

Pain with intercourse
___Never ___Occasionally ___Almost Always

Vaginal dryness
___Never ___Occasionally ___Almost Always

Difficulty Concentrating? ___Not a Problem ___Getting Worse

Memory Loss? ___Not a Problem ___Getting Worse

Mood Swings ____ Never ____Rarely ____Occasionally ____Frequently ____Daily

Depression ____ Never ____Rarely ____Occasionally ____Frequently ____Daily

Anxiety ____ Never ____Rarely ____Occasionally ____Frequently ____Daily

Headaches ____ Never ____ 1-3x/month ____Weekly

Muscle Pain ____ Never ____ 1-3x/month ____Weekly

Joint Pain ____ Never ____ 1-3x/month ____Weekly

Are you taking your medication for any of the above symptoms? __Yes __No

Are you taking herbal supplements/mediations for any of the above symptoms? __Yes __No