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ANNUAL HEALTH UPDATE

PATIENT NAME:	BIRTHDATE ____/____/____ AGE ____ DATE ____
ADDRESS:	PHONE (DAY): _____ (EVENING) _____
PRIMARY CARE PHYSICIAN:	OTHER PHYSICIAN(S) AND SPECIALTIES:
WHY ARE YOU HERE TODAY?	CURRENT MEDICATIONS: <input checked="" type="checkbox"/> NONE
LAST MENSTRUAL PERIOD: ____/____/____	LAST PAP TEST: ____/____/____
ALLERGIES (DESCRIBE REACTION): <input checked="" type="checkbox"/> NONE	IF OVER 40, LAST MAMMOGRAM ____/____/____ LAST CHOLESTEROL ____/____/____ LAST COLORECTAL SCREENING ____/____/____ LAST BONE DENSITY SCAN ____/____/____
PHARMACY NAME/LOCATION/PHONE (REQUIRED)	

Since your last visit here:

SURGERIES:
ILLNESSES:

HAVE YOU CHANGED YOUR OCCUPATION?

MAJOR STRESS AT HOME/WORK?

HAS THERE BEEN ANY CHANGES IN YOUR RELATIONSHIP WITH YOUR HUSBAND, PARTNER, OR BOYFRIEND? _____
ANY CHANGE IN YOUR FAMILY MEDICAL HISTORY? _____

HAS THERE BEEN A CHANGE IN YOUR PERIODS?

ARE YOU AND YOUR PARTNER USING ANY CONTRACEPTION? YES ____ No ____
IF YES, WHAT KIND? _____ ARE YOU SATISFIED WITH YOUR METHOD? YES ____ NO ____

DO YOU WANT ANY INFORMATION ON BIRTH CONTROL? _____

ARE YOU HAVING ANY DISCOMFORT OR PROBLEM WITH INTERCOURSE? _____

DO YOU HAVE ANY QUESTIONS OR PROBLEMS THAT YOU WOULD LIKE TO DISCUSS?

PATIENT'S NAME _____

BIRTH DATE: ___/___/___

TODAY'S DATE: ___/___/___

SOCIAL HISTORY (SH)			
	YES	NO	NOTES
TOBACCO USE	<input type="checkbox"/>	<input type="checkbox"/>	
ALCOHOL USE	<input type="checkbox"/>	<input type="checkbox"/>	
DOMESTIC VIOLENCE	<input type="checkbox"/>	<input type="checkbox"/>	
HEALTHHAZARDS AT HOME/WORK	<input type="checkbox"/>	<input type="checkbox"/>	
SEAT BELT USE	<input type="checkbox"/>	<input type="checkbox"/>	
DIET DISCUSSED	<input type="checkbox"/>	<input type="checkbox"/>	
FOLIC ACID INTAKE	<input type="checkbox"/>	<input type="checkbox"/>	
CALCIUM/VITAMIN D INTAKE	<input type="checkbox"/>	<input type="checkbox"/>	
BABY ASPIRIN	<input type="checkbox"/>	<input type="checkbox"/>	
REGULAR EXERCISE	<input type="checkbox"/>	<input type="checkbox"/>	
CAFFEINE INTAKE	<input type="checkbox"/>	<input type="checkbox"/>	
OTHER	<input type="checkbox"/>	<input type="checkbox"/>	
NO CHANGES SINCE: ___/___/___			

HAVE YOU RECENTLY HAD ANY OF THE FOLLOWING SYMPTOMS?

CONSTITUTIONAL	<input type="checkbox"/> NEGATIVE	<input type="checkbox"/> WEIGHTLOSS	<input type="checkbox"/> WEIGHT GAIN
	<input type="checkbox"/> FEVER	<input type="checkbox"/> FATIGUE	<input type="checkbox"/> OTHER
EYES	<input type="checkbox"/> NEGATIVE	<input type="checkbox"/> VISION CHANGE	<input type="checkbox"/> GLASSES/CONTACTS <input type="checkbox"/> OTHER
EAR,NOSE, & THROAT	<input type="checkbox"/> NEGATIVE	<input type="checkbox"/> ULCERS	<input type="checkbox"/> SINUSITIS
	<input type="checkbox"/> HEADACHE	<input type="checkbox"/> HEARING LOSS	<input type="checkbox"/> OTHER
CARDIOVASCULAR	<input type="checkbox"/> NEGATIVE	<input type="checkbox"/> CHEST PAIN	<input type="checkbox"/> DIFFICULTY BREATHING ON EXERTION
	<input type="checkbox"/> EDEMA	<input type="checkbox"/> PALPITATIONS	<input type="checkbox"/> OTHER
RESPIRATORY	<input type="checkbox"/> NEGATIVE	<input type="checkbox"/> WHEEZING	<input type="checkbox"/> COUGH
	<input type="checkbox"/> SHORTNESS OF BREATH	<input type="checkbox"/> OTHER	
GASTROINTESTINAL	<input type="checkbox"/> NEGATIVE	<input type="checkbox"/> DIARRHEA	<input type="checkbox"/> BLOODY STOOL
	<input type="checkbox"/> NAUSEA/COMITING/INDIGESTION		
	<input type="checkbox"/> CONSTIPATION	<input type="checkbox"/> FLATULENCE	<input type="checkbox"/> PAIN <input type="checkbox"/> FECAL INCONTINENCE
	<input type="checkbox"/> OTHER		
BLADDER	<input type="checkbox"/> NEGATIVE	<input type="checkbox"/> HEMATURIA	<input type="checkbox"/> DYSURIA <input type="checkbox"/> URGENCY
	<input type="checkbox"/> FREQUENCY	<input type="checkbox"/> INCOMPLETE EMPTYING	<input type="checkbox"/> INCONTINENCE
GYNECOLOGIC	<input type="checkbox"/> NEGATIVE	<input type="checkbox"/> PMS	<input type="checkbox"/> PAINFUL INTERCOURSE
	<input type="checkbox"/> ABNORMAL OR PAINFUL PERIODS	<input type="checkbox"/> ABNORMAL VAGINAL DISCHARGE	
	<input type="checkbox"/> OTHER		
MUSCULOSKELETON	<input type="checkbox"/> NEGATIVE	<input type="checkbox"/> MUSCLE WEAKNESS	<input type="checkbox"/> MUSCLE OR JOINT PAIN
	<input type="checkbox"/> OTHER		
SKIN	<input type="checkbox"/> NEGATIVE	<input type="checkbox"/> RASH	<input type="checkbox"/> ULCERS
	<input type="checkbox"/> DRY SKIN	<input type="checkbox"/> PIGMENTED LESIONS	<input type="checkbox"/> OTHER
BREAST	<input type="checkbox"/> NEGATIVE	<input type="checkbox"/> PAIN	<input type="checkbox"/> SELF BREAST EXAM
	<input type="checkbox"/> DISCHARGE	<input type="checkbox"/> MASSES	<input type="checkbox"/> OTHER
NEUROLOGIC	<input type="checkbox"/> NEGATIVE	<input type="checkbox"/> FAINTING	<input type="checkbox"/> SEIZURES <input type="checkbox"/> NUMBNESS
	<input type="checkbox"/> TROUBLE WALKING	<input type="checkbox"/> SEVERE MEMORY PROBLEMS	<input type="checkbox"/> OTHER
PSYCHIATRIC	<input type="checkbox"/> NEGATIVE	<input type="checkbox"/> DEPRESSION	<input type="checkbox"/> CRYING
	<input type="checkbox"/> SEVERE ANXIETY	<input type="checkbox"/> OTHER	
ENDOCRINE	<input type="checkbox"/> NEGATIVE	<input type="checkbox"/> DIABETES	<input type="checkbox"/> HYPOTHYROID <input type="checkbox"/> HYPERTHYROID
	<input type="checkbox"/> HOT FLASHES	<input type="checkbox"/> HAIR LOSS	<input type="checkbox"/> HEAT/COLD INTOLERANCE <input type="checkbox"/> OTHER
HEMATOLOGIC/LYMPHATIC	<input type="checkbox"/> NEGATIVE	<input type="checkbox"/> BRUISES	
	<input type="checkbox"/> BLEEDING	<input type="checkbox"/> ENLARGED LYMPH NODES	<input type="checkbox"/> OTHER