SOUTHEAST OB/GYN, ESTABLISHED ANNUAL HISTORY FORM

(rev 10/09)

Name_______________________ Phone #_______________________ Date_______________

Age__________Birth Date_______________Marital Status: S M Sep W D Current Job_______________

Primary Care Provider_______________________________Office Location_______________

When was the last visit with your Primary Care Provider?_______________________

List current medications / vitamins / herbs	List any known drugs you are allergic to including latex

Birth control method _______________________________________

No Yes

☐ ☐ Have you had any new medical problems or surgeries since your last visit? Please describe:_______________

☐ ☐ Have any of your family members had any new medical problems or surgeries since your last visit? Please describe:_______________

REVIEW OF SYSTEMS: Are you experiencing any problems the following conditions? Please indicate yes or no to all.

No	Yes		No	Yes		No	Yes	
☐	☐	Wt loss/gain > 10 lbs	☐	☐	Epilepsy/seizures	☐	☐	Breast discharge
☐	☐	Fatigue	☐	☐	Diabetes	☐	☐	Breast problems
☐	☐	Chest pain	☐	☐	Thyroid problems	☐	☐	Constipation/diarrhea
☐	☐	Heart palpitations	☐	☐	Dizziness	☐	☐	Abdominal pain
☐	☐	Edema/swelling	☐	☐	Numbness or tingling of extremities	☐	☐	Bloody stool
☐	☐	Frequent cough				☐	☐	Urinary urgency/frequency
☐	☐	Shortness of breath	☐	☐	Headaches	☐	☐	Loss of urine
☐	☐	Muscle weakness	☐	☐	Bruising	☐	☐	Urinary problems
☐	☐	Loss of height	☐	☐	Unusual bleeding	☐	☐	Sexual problems
☐	☐	Depression/anxiety	☐	☐	Swollen glands	☐	☐	Vaginal problems
☐	☐	Physical/mental abuse	☐	☐	Rashes	☐	☐	Abnormal/irregular periods
☐	☐	Hot flashes	☐	☐	Breast pain			

WELLNESS

No Yes

☐ ☐ Smoke How much per day______How long______

☐ ☐ Drink alcohol How much per day______How long______

☐ ☐ Use drugs How much per day______How long______

☐ ☐ Caffeine How much per day______How long______

☐ ☐ Get enough calcium (1200 mg daily)?

☐ ☐ Do monthly self breast exams?

☐ ☐ Always wear your seat belt?

☐ ☐ Exercise? Type & freq.___________

☐ ☐ Are you current with dental care?

☐ ☐ Are you on any particular diet?

☐ ☐ Do you have a health care proxy?

☐ ☐ 3 Gardasil Vaccinations completed (if < age 27)

Date of your last:

___________ Pap Smear

___________ Mammogram

___________ Bone Density test

___________ Cholesterol test (if over age 35)

___________ Tetanus immunization (every 10 yrs)

___________ Pneumonia immunization (if over age 65)

___________ Sigmoidoscopy/colonoscopy (if > age 50)

___________ Stool test for blood (if over age 50)

DO YOU WANT INFORMATION REGARDING:

☐ Self breast exams
☐ Vitamins
☐ Osteoporosis
☐ Contraception
☐ Health care proxy
☐ Colon cancer
☐ Infertility
☐ Menopause
☐ Advance care directives
☐ Urine Loss
☐ Hormone replacement therapy
☐ Sexually transmitted diseases

DO YOU WANT:

☐ A chaperone With Exam ☐ HIV Testing ☐ Sexual Disease Testing

Do you have any problems or concerns that you would like to discuss with your physician today? _______________

Patient's Signature_______________________________Date_______________

OFFICE USE ONLY:

I have reviewed the above and personally discussed with the patient _______________________ M.D. Date_____________