

# NORTH POINTE OB/GYN

## Annual Health History Update

Name \_\_\_\_\_ Age \_\_\_\_\_ Marital Status \_\_\_\_\_ Date \_\_\_\_\_

Why are you here today? \_\_\_\_\_

Do you have any new medical concerns today? Y N \_\_\_\_\_

Current Medications: \_\_\_\_\_

Medication Allergies: Y N \_\_\_\_\_ Are you allergic to Latex: Y N

Name of your primary / family physician \_\_\_\_\_

Menstrual Cycle History: 1<sup>st</sup> day of last period \_\_\_\_\_ Was it normal? Y N

Are your periods regular? Y N

Do you have:	Excessive bleeding	Y N	Mood Swings	Y N
	Pain / Cramps	Y N	Bleeding between periods	Y N

Are you sexually active? Y N Do you have pain with intercourse? Y N

What are you doing to prevent pregnancy? None Condoms Tubal Ligation Vasectomy IUD  
Depo-Provera Ring Patch Pills (fill in name) \_\_\_\_\_ Other \_\_\_\_\_

Are you happy with this method? Y N If no, do you want a different method? Y N

Have you ever had an abnormal pap smear? Y N If yes, when \_\_\_\_\_

Do you smoke? Y N If yes, how much \_\_\_\_\_ Do you exercise? Y N Describe \_\_\_\_\_

Are you having any urinary problems? Y N If yes, explain \_\_\_\_\_

Are you having any problems with vaginal discharge? Y N If yes, explain \_\_\_\_\_

Have you had? A mammogram: Y N When \_\_\_\_\_ A bone density: Y N When \_\_\_\_\_

A colonoscopy: Y N When \_\_\_\_\_ Your "cholesterol" checked: Y N When \_\_\_\_\_

Have there been any new medical problems (i.e. cancer) among your immediate family members since your last visit? Y N

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XXXXXXXXXXXXXXXXXXXX PATIENTS PLEASE DO NOT WRITE BELOW THIS LINE XXXXXXXXXXXXXXXXXXXX