DATE_____

PENFIELD OBSTETRICS & GYNECOLOGY, LLP
ANNUAL HEALTH UPDATE FOR ESTABLISHED PATIENTS

Name_____ Date of Birth_____ Age_____ Marital Status_____

Home Phone (_____) _____ Cell (_____) _____ Work (_____) _____

Emergency Contact Name & Relationship _____ Phone (____) _____

Reason for visit _____

Problems/Concerns _____

Date of Last Mammogram_____ Date of Last Dexa Scan_____

Medications ▪ New medications or changes since your last visit (include dosage): ☐ **No changes since last visit**

MEDICATION	DOSE	FREQUENCY

▪ Allergies_____ ▪ **Latex Allergy? ☐ YES ☐ NO**

Obstetric History

# Pregnancies? _____	# Miscarriages? _____	# Terminations? _____	☐ Never Been Pregnant
# Full Term Deliveries? _____	# Preterm Deliveries? _____	# Living Children? _____	☐ Children are Adopted

Menstrual Cycle

▪ First day of your last period? _____ ▪ Cycles are ☐ Regular ☐ Irregular

*****If you no longer have menstrual cycles, check the reason below and enter the year your cycles stopped:***

☐ Post Menopausal Year_____ ☐ Hysterectomy Year_____ ▪ Do you use HRT? ☐ Yes ☐ No

Current Contraceptive Method(s) – check all that apply

☐ None	☐ Diaphragm	☐ Partner Vasectomy	☐ Female Partner	IUD ☐ Mirena
☐ Condoms	☐ Natural Family Planning	☐ Tubal Ligation	☐ Implanon/Nexplanon Device	☐ Skyla
☐ Birth Control Pills – List Brand_____		☐ Depo Provera	☐ Other_____	☐ Paragard

Family Medical History – check if any blood relatives have/had the following cancers: ☐ **No changes since last visit**

☐ Breast	☐ Ovarian	☐ Uterine	☐ Colon	Other (please list)_____

Personal Health History Changes ☐ **No changes since last visit**

▪ Please list any recent surgeries you have had: _____

▪ Please list any newly diagnosed health problems and/or injuries since your last visit: _____

_____

Social History

▪ Do you smoke? ☐ NO ☐ YES Packs Per Day_____ ▪ Do you drink alcohol? ☐ NO ☐ YES Drinks Per Week_____

▪ Do you exercise? ☐ NO ☐ YES Type_____ Days Per Week_____