UPDATED MEDICAL HISTORY

TODAY'S DATE:

NAME: _____ AGE:_____ DOB:_____

MEDICAL HISTORY:

PLEASE LIST ANY NEW MEDICAL CONDITIONS ***SINCE YOUR LAST VISIT*** (IF APPLICABLE)

_____

_____

SURGICAL HISTORY:

PLEASE LIST ANY RECENT SURGERIES YOU HAVE HAD ***SINCE YOUR LAST VISIT*** (IF APPLICABLE)

_____

_____

GYNECOLOGICAL HISTORY:

PLEASE LIST ANY CHANGES IN YOUR GYNECOLOGICAL HISTORY *SINCE YOUR LAST VISIT*

LAST MENSTRUAL PERIOD:_____ DURATION:_____ Flow:_____

ARE YOU SEXUALLY ACTIVE? Y N IF SO, WITH MALE FEMALE BOTH

DO YOU HAVE ANY SEXUALITY ISSUES YOU WISH TO DISCUSS? _____

ARE YOU CURRENTLY USING ANY FORM OF BIRTH CONTROL? Y N TYPE:_____

SOCIAL HISTORY:

PLEASE LIST ANY CHANGES IN YOUR SOCIAL HISTORY IF APPLICABLE

TOBACCO USE?	Y	N	YEARS? _____	PACKS PER DAY? _____
DO YOU DRINK ALCOHOL?	Y	N	WHAT KIND? _____	FREQUENCY? _____
DO YOU DRINK CAFFEINE?	Y	N	WHAT KIND? _____	HOW OFTEN? _____
DO YOU EXERCISE?	Y	N	WHAT TYPE? _____	HOW OFTEN? _____

REVIEW OF SYSTEMS

DO YOU HAVE ANY ABNORMALITIES OF:			IF YES, PLEASE EXPLAIN
SKIN	Y	N	_____
ENDOCRINE SYSTEM (THYROID PROBLEMS, DIABETES)	Y	N	_____
NERVOUS SYSTEM	Y	N	_____
EYES	Y	N	_____
RESPIRATORY SYSTEM	Y	N	_____
ALLERGIES	Y	N	_____
BLOOD	Y	N	_____
URINARY SYSTEM (INCONTINENCE, URGENCY OR INFECTIONS)	Y	N	_____
EARS, NOSE AND THROAT	Y	N	_____
HEART OR VASCULAR SYSTEM	Y	N	_____
DIGESTIVE SYSTEM	Y	N	_____
MUSCLES OR JOINTS	Y	N	_____

HAVE YOU HAD ANY PHSYCHOLOGICAL PROBLEMS, DEPRESSION OR ANXIETY? _____

Patient Signature:_____ Date:_____

Jeanette Pilotte
MD, FACOG
WOMEN'S HEALTH & WELLNESS

MEDICATION LIST

PATIENT NAME:_____ DATE:_____/_____/_____

DRUG ALLERGIES **REACTION**

_____

_____

_____

_____

Are you allergic to latex? ___ yes ___ no

CURRENT MEDICATIONS

NAME	DOSE	TIMES PER DAY	REASON

VITAMINS & SUPPLEMENTS

NAME	DOSE	TIMES PER DAY

PREFERRED PHARMACY:_____