Ivinson MEMORIAL HOSPITAL
MEDICAL GROUP

OB/GYN Annual Patient History Update

Name:_____ Date of Birth:_____

Preferred Name:_____ Pronouns:_____

Reason for today's visit:_____

Health Update List any changes since your last visit to the following:

Medications: _____

Medical History: _____

Surgical History: _____

Family History: _____

Allergies: _____

Social History:

Do you smoke cigarettes or e-cigarettes? ☐Yes ☐No How much?_____

Do you use chewing tobacco, snuff, or other forms of tobacco? ☐Yes ☐No

Do you use recreational drugs (marijuana, etc.)? ☐Yes ☐No

Please list what type:_____

Do you drink alcohol? ☐Yes ☐No

How many glasses of wine/liquor, mixed drinks, beer per week? _____

What is your occupation? _____

Gynecologic Hystory:

When was the first day of your last menstrual period? ____/____/____

How many days from the start of the period to the start of the next period? _____

How many days do they typically last? _____

Is your flow ☐Light ☐Moderate ☐Heavy Do you have painful periods? ☐Yes ☐No

Do you bleed/spot between periods? ☐Yes ☐No

What is your sexual orientation? _____

Are you sexually active? ☐Yes ☐No

Are you taking hormones or using birth control?_____

Have you ever had a sexually transmitted infection? ☐Yes ☐No

If so, which? _____ When? ____/____/____

Have you ever been a victim of abuse? ☐Yes ☐No

Check all that apply: ☐Physical ☐Sexual ☐Verbal

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Please mark yes for any ***current symptoms*** you have.

Constitutional
Weight Gain ☐Yes ☐No
Weight Loss ☐Yes ☐No
Fatigue ☐Yes ☐No
Hot Flashes ☐Yes ☐No
Night Sweats ☐Yes ☐No

Eyes
Double Vision ☐Yes ☐No
Blurred Vision ☐Yes ☐No

HENT
Sore Throat ☐Yes ☐No
Headaches ☐Yes ☐No
Nasal Congestion ☐Yes ☐No
Ringing in Ears ☐Yes ☐No
Sinus Problems ☐Yes ☐No
Dental Problems ☐Yes ☐No

Breast
Lumps ☐Yes ☐No
Tenderness ☐Yes ☐No
Swelling ☐Yes ☐No
Redness ☐Yes ☐No
Nipple Discharge ☐Yes ☐No

Cardiovascular
Chest Pain ☐Yes ☐No
Irregular Heartbeat ☐Yes ☐No
Leg Swelling ☐Yes ☐No
Rapid Heartrate ☐Yes ☐No
Blood Clot ☐Yes ☐No
Shortness of Breath on Exertion ☐Yes ☐No

Respiratory
Shortness of Breath ☐Yes ☐No
Chronic Cough ☐Yes ☐No
Wheezing ☐Yes ☐No
Pain with Deep Breathing ☐Yes ☐No

Neurologic
Dizziness ☐Yes ☐No
Seizures ☐Yes ☐No
Memory Loss ☐Yes ☐No
Numbness ☐Yes ☐No

Gastrointestinal
Nausea ☐Yes ☐No
Vomiting ☐Yes ☐No
Constipation ☐Yes ☐No
Diarrhea ☐Yes ☐No
Blood in Stool ☐Yes ☐No
Heartburn ☐Yes ☐No

Genitourinary
Urgency ☐Yes ☐No
Frequency ☐Yes ☐No
Painful Urination ☐Yes ☐No
Blood in Urine ☐Yes ☐No
Nighttime Urination ☐Yes ☐No
Incontinence ☐Yes ☐No
Heavy Periods ☐Yes ☐No
Irregular Periods ☐Yes ☐No
Painful Periods ☐Yes ☐No
Bleeding with Intercourse ☐Yes ☐No
Significant PMS ☐Yes ☐No
Decreased Sex Drive ☐Yes ☐No

Integument
Rash ☐Yes ☐No
Itching ☐Yes ☐No
Abnormal Hair Growth ☐Yes ☐No

Musculoskeletal
Muscle Pain ☐Yes ☐No
Joint Pain ☐Yes ☐No
Muscular Weakness ☐Yes ☐No

Endocrine
Abnormal Thirst ☐Yes ☐No
Loss of Hair ☐Yes ☐No
Cold Intolerance ☐Yes ☐No
Heat Intolerance ☐Yes ☐No

Psychiatric
Anxiety ☐Yes ☐No
Stress ☐Yes ☐No
Depression ☐Yes ☐No
Suicidal Ideation ☐Yes ☐No

Heme-Lymph
Easy Bruising ☐Yes ☐No
Easy Bleeding ☐Yes ☐No
Enlarged Lymph Node ☐Yes ☐No
Lightheadedness ☐Yes ☐No
Blood Clotting Abnormality ☐Yes ☐No

Allergic/Immunologic
Seasonal Allergies ☐Yes ☐No
Allergic Dermatitis ☐Yes ☐No