Please print a copy of this form and bring it with you to your appointment.

Complete WOMENS CARE CENTER
obstetrics gynecology menopause fertility wellness cosmetic gynecology

HISTORY UPDATE

NAME:_____

DATE:_____

Thank you for taking the time to answer these questions.
Most insurance companies require this information to be updated at ***every*** *visit.*

Please check any symptoms which you are currently experiencing

Constitutional
- ☐ Fatigue
- ☐ Weight loss
- ☐ Weight gain

Head, Ears, Nose,Throat
- ☐ Headache
- ☐ Sore throat
- ☐ Decreased hearing

Breast
- ☐ Breast lumps
- ☐ Breast tenderness
- ☐ Nipple discharge

Cardiovascular
- ☐ Chest pain
- ☐ Irregular heartbeat

Respiratory
- ☐ Cough
- ☐ Wheezing
- ☐ Shortness of breath

Gastrointestinal
- ☐ Nausea/vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Abdominal pain

Skin/Hair
- ☐ Rash
- ☐ Skin lesions

Neurologic
- ☐ Seizures
- ☐ Tingling
- ☐ Numbness

Musculoskeletal
- ☐ Joint pain
- ☐ Joint swelling

Endocrine
- ☐ Hair loss
- ☐ Temperature intolerance
- ☐ Abnormal hair growth

When was your last menstrual period?

_____

Have you had any serious illnesses, operations or hospitalizations since your last visit?

_____

Have you discovered any additional information about your family history that we should know?

_____

Have you changed any habits (smoking, drinking etc.) or occupation since your last visit?

_____

Please list all current medications and doses including herbals and vitamins

_____ _____ _____

_____ _____ _____

Please list any current allergies

_____

Please briefly describe the reason for your visit today

_____

_____

Thank you!