ASSOCIATES IN women's health

Medical History Update

Please check if you are now or recently experiencing any of the following:

Constitutional: ☐ Anorexia/Bulemia ☐ Weight loss ☐ Weight gain ☐ Fatigue ☐ Sweating ☐ Fever

Eyes: ☐ Vision loss ☐ Double vision ☐ Spots

Ear/Nose/Throat: ☐ Ringing in ear ☐ Earache ☐ Sore throat ☐ Bleeding gums ☐ Congestion

Cardiac: ☐ Chest pain ☐ Palpitations ☐ Swelling (location _____)

Respiratory: ☐ Wheezing ☐ Cough ☐ Shortness of breath

GI: ☐ Constipation ☐ Diarrhea ☐ Bloating ☐ Black or bloody stools

GU: Urine: ☐ Frequency ☐ Urgency ☐ Burning ☐ Incontinence ☐ Pain

Periods: ☐ Cramps ☐ Irregular ☐ Heavy ☐ Spotting ☐ PMS

Vagina: ☐ Dryness ☐ Itching ☐ Discharge ☐ Painful intercourse

Menopause: ☐ Hot flashes ☐ Night sweats ☐ Other _____

Muscle: ☐ Joint pain ☐ Muscle cramps ☐ Weakness

Skin: ☐ Rash ☐ Dryness ☐ Lesions ☐ Acne ☐ Moles

Breast: ☐ Lump ☐ Discharge ☐ Pain ☐ Skin changes

Neuro: ☐ Headaches ☐ Dizziness ☐ Tremors ☐ Weakness ☐ Seizures

Psych: ☐ Depression ☐ Anxiety ☐ Insomnia ☐ Memory loss ☐ Moodiness

Endo: ☐ Excess thirst ☐ Hair loss ☐ Excess hair ☐ Cold/heat intolerance ☐ Excess urination

Lymph: ☐ Bruising ☐ Nosebleeds ☐ Swollen glands

Do you smoke? ☐ Yes ☐ No

Is anyone physically or emotionally hurting you? ☐ No ☐ Yes, Who?_____

Please list current **PRESCRIBED** medications you are taking along with the strength and dose.

MEDICATION	STRENGTH	DOSE

Continued on reverse side

Please list current **OVER THE COUNTER** medications you are taking along with the strength and dose.

MEDICATION	STRENGTH	DOSE

1st day of last period? _____

What concerns do you want to discuss at today's appointment? _____

_____

What symptoms do you want to discuss with the provider? _____

_____

Other physician/provider visits since last time here (for same condition)? ☐ Yes ☐ No
If yes, (who/where): _____

Do you have specific requests for:

- ☐ New Medication(s): _____
- ☐ Refills: _____
- ☐ Vaccinations: _____
- ☐ Referrals: _____
- ☐ Tests: _____
- ☐ Completion of forms: _____
- ☐ School or work release: _____
- ☐ Other: _____

SIGNATURE: _____ DOB : _____ DATE : _____