Women's Health of Oregon

CONFIDENTIAL MEDICAL HISTORY UPDATE

Date:_____ Name:_____ DOB: _____

Preferred Name:_____ Primary Care Provider:_____

Have you had any of the following tests since your last visit? If yes, please indicate DATES**.**

() Pap Smear_____ () Mammogram_____ () Colonoscopy_____

() Bone Density Scan_____ () Blood Sugar Level_____ () Eye Exam_____

() Cholesterol Panel_____ () Surgery_____ () Other_____

MEDICATIONS/SUPPLEMENTS

() NONE

Medication Name and Dose Instructions Prescribed by

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Changes to Personal or Family Medical History If yes, please list. () YES () NO

_____

_____

Last Menstrual Period (First day)_____ Was this a normal period? ()YES ()NO

What is your current form of birth control? _____ (pills, condoms, vasectomy, ect.)

Do you desire to change your birth control method at this time?_____

() Single () Married () Partnered () Divorced () Separated ()Widowed

Number of sexual partners in the last 1 year_____ 3 years_____

Alcohol () NONE _____ drinks per week **Caffeine** () NONE _____ drinks per day

Tobacco () NONE _____ cigarettes per day age started_____ age quit_____

Recreational Drug Use () NONE I use_____ how often_____

Exercise: () NONE ()Active but no formal exercise () Once a week or less

() One to three times a week () Four or more times per week

What health concerns/problems do you wish to discuss today?_____

_____

Review of Systems

Are you *currently* experiencing any of the following symptoms?

Please mark the circle if you are.

constitutional

() fever
() chills
() sweats
() weight change – gain or loss
() weakness
() fatigue

eyes

() change in vision

ears, nose, mouth, throat

() change in hearing
() nose bleeds
() sore throat
() dry mouth

cardiovascular

() dizziness
() shortness of breath
() chest pain
() loss of consciousness
() palpitations

respiratory

() cough – productive or dry
() wheezing

gastrointestinal

() abdominal pain
() nausea, vomiting
() change in bowel habits
() change in appetite
() dark or bloody stool
() indigestion
() constipation or diarrhea
() bloating for more than 30 days

hematologic / lymphatic

() swollen lymph glands
() bruise easily

gynecological

() bleeding or pain with intercourse
() unusual vaginal discharge or odor
() vulvar or vaginal itching or burning
() pelvic pain
() bleeding after menopause

musculoskeletal

() back pain
() weakness
() joint pain, stiffness, swelling

urinary

() painful
() frequent

() urgency
() blood in urine
() urinary incontinence
() getting up at night to urinate

integumentary / breast

() nodules
() change in moles, freckles
() change in hair – growth, loss, texture

() lumps
() nipple discharge
() pain

neurological / psychiatric

() numbness or tingling
() memory change
() depression
() anxiety
() mood swings

endocrine

() excessive thirst
() tremor
() sleep disturbances

() cold or heat intolerance

() hot flashes
() night sweats

() NO CURRENT SYMPTOMS

Thank you for carefully filling this out,
we appreciate you.