Gynecology Update Form

Name _____ Age _____ Date of Birth _____ Date _____/_____/_____

PAST MEDICAL HISTORY:

Since your last visit have you been diagnosed with any new HEALTH PROBLEMS? ☐ YES ☐ NO

If YES, please describe _____

PAST SURGICAL HISTORY:

Have you had any recent SURGERY? ☐ YES ☐ NO

If YES, please describe _____

MEDICATIONS:

Please list all your PRESCRIBED MEDICATIONS:

Medication	Dose	Medication	Dose
1. _____	_____	5. _____	_____
2. _____	_____	6. _____	_____
3. _____	_____	7. _____	_____
4. _____	_____	8. _____	_____

Please list all the OVER-THE-COUNTER MEDICATIONS, SUPPLEMENTS, and VITAMINS you take on a regular basis:

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

ALLERGIES:

Have you developed any new ALLERGIES TO MEDICATIONS? ☐ YES ☐ NO

If YES, please give name of medication and reaction _____

_____

PREVENTATIVE HEALTH MAINTENANCE:

When was your last MAMMOGRAM? _____/_____/_____ ☐ NEVER

When was your last BONE DENSITY STUDY? _____/_____/_____ ☐ NEVER

When was your last COLONOSCOPY? _____/_____/_____ ☐ NEVER

If you are over 65, have you ever received a pneumonia vaccine? ☐ YES ☐ NO ☐ N/A

Did you receive a flu vaccine during the most recent flu season (September-February)? ☐ YES ☐ NO

Women's Medical Associates of Nashville
AdvancedHEALTH

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FAMILY HISTORY:

Have there been any CHANGES in your FAMILY HISTORY? ☐ YES ☐ NO

If YES, please note changes:

M= Mother **F**= Father **S**= Sister **B**= Brother **MGM**= Maternal grandmother **MGF**= Maternal grandfather
PGM= Paternal grandmother **PGF**= Paternal grandfather

1.	High blood pressure	☐ M	☐ F	☐ S	☐ B	☐ MGM	☐ MGF	☐ PGM	☐ PGF
2.	Diabetes	☐ M	☐ F	☐ S	☐ B	☐ MGM	☐ MGF	☐ PGM	☐ PGF
3.	Heart disease	☐ M	☐ F	☐ S	☐ B	☐ MGM	☐ MGF	☐ PGM	☐ PGF
4.	Breast cancer	☐ M	☐ F	☐ S	☐ B	☐ MGM	☐ MGF	☐ PGM	☐ PGF
5.	Ovarian cancer	☐ M	☐ F	☐ S	☐ B	☐ MGM	☐ MGF	☐ PGM	☐ PGF
6.	Colon cancer	☐ M	☐ F	☐ S	☐ B	☐ MGM	☐ MGF	☐ PGM	☐ PGF
7.	Thyroid disorder	☐ M	☐ F	☐ S	☐ B	☐ MGM	☐ MGF	☐ PGM	☐ PGF
8.	Osteoporosis	☐ M	☐ F	☐ S	☐ B	☐ MGM	☐ MGF	☐ PGM	☐ PGF
9.	Blood clotting disorder	☐ M	☐ F	☐ S	☐ B	☐ MGM	☐ MGF	☐ PGM	☐ PGF
10.	Deep venous thrombosis *(DVT – blood clot deep in leg)*	☐ M	☐ F	☐ S	☐ B	☐ MGM	☐ MGF	☐ PGM	☐ PGF
11.	Autoimmune disorders *(such as lupus, rheumatoid arthritis, etc)*	☐ M	☐ F	☐ S	☐ B	☐ MGM	☐ MGF	☐ PGM	☐ PGF
12.	Other _____								

MENSTRUAL HISTORY:

If you are still having periods:

- When was your LAST MENSTRUAL PERIOD? _____
- Are your periods ☐ REGULAR or ☐ IRREGULAR?
- How many DAYS are there BETWEEN your cycles? _____
- How many DAYS do your periods LAST? _____
- Are your periods: ☐ LIGHT ☐ MODERATE ☐ HEAVY
- Do you frequently SPOT between periods? ☐ YES ☐ NO
- Do you pass large CLOTS with your periods? ☐ YES ☐ NO _____
- Describe your CRAMPS: ☐ None ☐ MILD ☐ MODERATE ☐ SEVERE _____

If you are POST-MENOPAUSAL do you have any significant MENOPAUSAL SYMPTOMS? ☐ YES ☐ NO

☐ HOT FLASHES ☐ NIGHT SWEATS ☐ VAGINAL DRYNESS ☐ OTHER _____

Are you currently SEXUALLY ACTIVE? ☐ YES ☐ NO ☐ WITH MEN ☐ WITH WOMEN

If YES, what do you use to PREVENT PREGNANCY? _____

Do you need to CHANGE your BIRTH CONTROL METHOD? ☐ YES ☐ NO

SOCIAL HISTORY:

Do you drink ALCOHOL? ☐ Rarely ☐ Occasionally ☐ Daily ☐ Never _____

Do you smoke? ☐ YES ☐ NO

If YES, check any that apply: ☐ CIGARETTES ☐ VAPING ☐ E-CIGARETTES ☐ MARIJUANA

Do you use any ILLICIT SUBSTANCES? ☐ YES ☐ NO _____

Are you ☐ MARRIED ☐ SINGLE ☐ WIDOWED ☐ DIVORCED ☐ SEPARATED?

Do you EXERCISE? ☐ Regularly ☐ Occasionally ☐ Never

Are you EMPLOYED outside the home? ☐ YES ☐ NO

If YES, what type of work do you do? *(if you are a student please include this information as well)*:

_____

Have you ever been a victim of DOMESTIC VIOLENCE? ☐ YES ☐ NO

REVIEW OF SYSTEMS:

Please **check** any SIGNIFICANT SYMPTOMS you currently experience: ☐ **NONE**

- **CONSTITUTIONAL:** ☐ weight gain ☐ weight loss ☐ fatigue ☐ loss of appetite ☐ fevers ☐ chills ☐ other _____
- **EYES:** ☐ blurred vision ☐ eye pain ☐ discharge from eye ☐ other _____
- **HEAD & NECK:** ☐ severe headaches ☐ sore throat ☐ nasal discharge ☐ nose bleeds ☐ decreased hearing ☐ lightheadedness ☐ other _____
- **BREAST:** ☐ lumps ☐ tenderness ☐ nipple discharge ☐ other _____
- **CARDIOVASCULAR:** ☐ chest pain ☐ irregular heartbeat ☐ fainting spells ☐ other _____
- **RESPIRATORY:** ☐ shortness of breath ☐ cough ☐ wheezing ☐ other _____
- **GASTROINTESTINAL:** ☐ nausea ☐ vomiting ☐ diarrhea ☐ constipation ☐ heartburn ☐ abdominal pain ☐ blood in stools ☐ incontinence of stools ☐ hemorrhoids ☐ other _____
- **GENITOURINARY:** ☐ urinary frequency ☐ pain with urination ☐ blood in urine ☐ urinary incontinence ☐ difficulty urinating ☐ vaginal discharge ☐ pain with intercourse ☐ bleeding with intercourse ☐ significant PMS ☐ other _____
- **SKIN:** ☐ rash ☐ itching ☐ acne ☐ abnormal hair growth ☐ other _____
- **NEURO:** ☐ headaches ☐ weakness ☐ numbness ☐ other _____
- **MUSCULOSKELETAL:** ☐ joint pain ☐ joint swelling ☐ muscle weakness ☐ muscle pain ☐ other _____
- **ENDOCRINE:** ☐ increased thirst ☐ increased urination ☐ hair loss ☐ heat intolerance ☐ cold intolerance ☐ other _____
- **PSYCHIATRIC:** ☐ anxiety ☐ depression ☐ confusion ☐ other _____
- **HEMATOLOGIC:** ☐ easy bruising ☐ easy bleeding ☐ lymph node enlargement ☐ other _____
- **ALLERGIC:** ☐ sinus allergies ☐ skin allergies ☐ other _____

I have filled out this form completely and to the best of my ability.

Signature _____ Date _____/_____/_____