Women's
Medical Associates of Nashville

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 of your PRESCRIBED MEDICATIONS:

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

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

1. _____ 3. _____
2. _____ 4. _____

ALLERGIES:

Have you developed any new ALLERGIES TO MEDICATIONS? YES NO

If YES, please give name of medication and reaction_____

PREVENTIVE HEALTH MAINTANENCE:

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

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	**M**	**F**	**S**	**B**	**MGM**	**MGF**	**PGM**	**PGF**	(blood clot deep in leg)
11.	Autoimmune disorder	**M**	**F**	**S**	**B**	**MGM**	**MGF**	**PGM**	**PGF**	(such as lupus, rheumatoid arthritis, etc)
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 - CLOTS?
- Do you frequently SPOT between periods? YES NO
- Describe your CRAMPS: None Mild Moderate Severe

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

HOT FLASHES NIGHT SWEATS VAGINAL DRYNESS OTHER_____

Are you currently SEXUALLY ACTIVE? YES NO

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 CIGARETTES? Occasionally Daily Never Quit

Do you use any ILLICIT SUBSTANCES? YES NO

Are you – MARRIED – SINGLE – ENGAGED – 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)?

_____

Do you have any issues with DOMESTIC VIOLENCE? YES NO

REVIEW OF SYSTEMS:

Please circle 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 heart beat – 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_____