

MEDICAL HISTORY UPDATE

Name: _____ DOB: _____ Age: _____ Date: _____

Reason for office visit: _____

My period cycles are: _____ monthly _____ every other month
_____ unpredictable _____ nonexistent.

*****For Doctors Use Only*****

My last period started on: _____

My periods normally last about _____ days and they are
_____ light _____ moderate _____ heavy flow.

Do you have cramps associated with you periods? Yes/No

Add'l Comments: _____

Have you developed any medical problems since your last visit?

Yes/No If yes please describe.

My present form of contraception is: _____

_____ Tubal Ligation _____ Partner had Vasectomy

Have you been hospitalized since your last visit? Yes/No

If yes please describe.

Do you have any allergies to any medications? Yes/No

List:

List medications you are currently taking, include dosages.

Do you exercise? Yes/No How many days a week? _____

Do you take vitamins? Yes/No If yes, which ones?

Do you take Calcium? Yes/No If yes, how much?

Do you smoke? If yes, how many packs per week? _____

Do you use recreational drugs? If yes which ones?

Are you involved in an abusive relationship? Yes/No

Do you drink alcoholic beverages? Yes/No If yes how
many per week? _____

Have you developed a chronic cough? Yes/No

Date of last Mammogram, if applicable: _____

Date of last Bone Density Scan if applicable: _____

Date of last bloodwork: _____

Patient Signature _____

Dr.'s Signature _____