CONFIDENTIAL HEALTH UPDATE

NAME_____ DATE_____ DOB_____ AGE_____

MARITAL STATUS M W D S RELIGION_____ OCCUPATION_____

FAMILY MD_____ REFERRED BY_____

CHIEF COMPLAINT ___ Here for annual exam

___Other reason. Please describe problem_____

_____

REVIEW OF SYSTEMS Please check if you have:

___Breast pain ___Breast lump ___Nipple discharge ___None Of These

___Bleeding between periods ___Vaginal discharge ___Pain with urination

___Frequent urination ___Urination leakage ___None Of These

MENSTRUAL HISTORY ____No periods (skip to next section)

Age Period Began_____ **First Day of Last Menstrual Period**_____

How often do you get your period? _____ ____Regular _____Irregular

Days of flow_____ **Amount of Flow** ____Light ____Average ____Heavy

Cramps __None __Mild __Moderate __Severe **PMS**__None __Mild __Moderate __Severe

SEXUAL HISTORY

Are you currently sexually active?	___Yes	___No
Do You Have A Female Partner?	___Yes	___No
Have you been abused or forced into sexual behavior?	___Yes	___No
Do you have bleeding with intercourse?	___Yes	___No
Do you have pain with intercourse?	___Yes	___No

Have you been exposed to AIDS, hepatitis, or other sexually transmitted diseases? ___Yes ___No

CONTRACEPTIVE USE Do you currently use any of the following:

___Depo Provera ___Natural Family Planning ___Tubal Ligation ___Birth Control Pills

___Condoms ___Partner Vasectomy ____Diaphragm ___Implanon or Explanon

___IUD (Mirena or Paragard) ____None ___Other (foam, vaginal suppository)

MEDICATION ALLERGIES AND REACTIONS:

1._____ 2._____ 3._____

4._____ 5._____ 6._____

FOOD OR ENVIRONMENTAL ALLERGIES_____

CURRENT PRESCRIPTIONS OR OVER-THE-COUNTER MEDICATIONS & VITAMINS (INCLUDE DOSAGE):

1._____ 2._____ 3._____

4._____ 5._____ 6._____

- PLEASE TURN OVER –

OPERATIONS: WHAT TYPE/WHEN_____

HOSPITALIZATIONS (DATE AND DIAGNOSIS)_____

PREGNANCIES_____ **FULL TERM DELIVERIES**_____ **PRETERM DELIVERIES**_____

MISCARRIAGE_____ **ABORTION**_____ **LIVING CHILDREN**_____

FAMILY HISTORY

___Heart Disease ___Diabetes ___High Blood Pressure ___Stroke

Check if any blood relatives have the following cancers: ___Ovarian ___Breast ___Colon Other_____

Adopted? ___Yes ___No

MEDICAL HISTORY AND HEALTH HABITS

__Rheumatic Fever __Kidney/Bladder Infections __Gall Bladder Problems __Sexually Transmitted Disease

__Hearing Defects __Jaundice __German Measles (3 day) __Depression

__Tuberculosis __Abnormal Pap Smear __Thyroid Problems __Asthma

__Seizures __Sexual Problems __Blood Disorders __Anemia

__Hepatitis __High Blood Pressure __High Cholesterol __Neurological Problems

__Genital Herpes __Genital Warts __Diabetes __Headaches

__Chicken Pox __Phlebitis __HIV Exposure __History of Cancer

__Excessive Bleeding After Injury or Surgery __Mitral Valve Prolapse (if yes, do you require antibiotics with any procedure?_____)

__Any other health problems?_____

Do you wear glasses?_____ Do you wear contacts?_____ Do you smoke?_____ Amount per day_____

Do you perform Self Breast Exam?_____ Do you drink alcohol?____ Amount per week_____

Do you exercise?_____ Type?_____ Amount?_____ Do you use drugs?____

Do you have routine dental exams?_____ Do you feel you have a problem with drug or alcohol use?_____

How many meals do you eat daily?_____ Do you wear a seat belt?_____

THIS AREA FOR NURSING NOTES

Vital Signs: **Height**_____ **Weight**_____ **BP**_____