Sandpoint Women's Health

Established Patient **Yearly Update** Health History Form

If nothing has changed in the specified categories below, write N/A.

Patient Name:_____ Date: _____

Reason for visit: _____ Age/Date of Birth: _____

Primary Care Provider: _____ Marital status: _____

PAST MEDICAL HISTORY:

Any new medical issues that have developed since your last visit? Examples: asthma, blood clots, cancer, high blood pressure, high cholesterol, heart disease, diabetes, thyroid disease, osteoporosis, etc.

_____

_____

GYNECOLOGIC/OBSTETRIC HISTORY:

Any new OB/GYN issues since you were last in? Examples: frequent UTI's, herpes, chlamydia, other STDs, incontinence, infertility, pregnancies, changes in bleeding, etc.

_____

_____

Have you received any vaccinations since your last visit?

_____

SURGICAL HISTORY: Write date and type of any new surgeries.

_____

_____

Current medications and supplements (with dosing and instructions): _____

_____

_____

Medications you are allergic to: _____ Y / N Latex Y / N Eggs Y / N Iodine

FAMILY MEDICAL HISTORY:

Have any family members developed any illnesses or cancer since your last visit? If yes, who and what type?

_____

_____

BASIC OB/GYN INFORMATION: First day of last period _____ Last Mammogram _____

Last Colonscopy _____ Last Dexa _____

Are you planning a pregnancy in the next year? _____

If applicable, what are you using for birth control? _____

Do you have any questions/concerns about your sexual life?_____

PERSONAL HEALTH HISTORY:

Occupation:_____

What do you do for exercise?_____

Have you ever been physically, emotionally, or sexually abused?_____

Do you drink alcohol? ☐ Y ☐ N Amount: Daily_____ Weekly _____ Monthly _____

Do you use tobacco? ☐ Former ☐ Never ☐ Current – amount used _____

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Name: _____ DOB: _____

REVIEW OF SYSTEMS - Please circle any symptoms that have troubled you during the last several weeks.

General	Fatigue	Unexplained weight loss	Unexplained weight gain
Eyes	Vision problems		
ENT	Sore throat Headache	Sinus congestion Nasal discharge	Ear ache
Cardiovascular	Chest pain	Heart palpitations/flutters	Swelling in feet
Respiratory	Cough Coughing up blood	Shortness of breath	Wheezing
GI	Nausea Diarrhea Rectal bleeding Abdominal pain	Vomiting Constipation Black, tarry stools	Heartburn Bloating Hemorrhoids
GU	Blood in urine Heavy periods Vaginal discharge	Painful urination Bleeding between periods Pelvic pain	Leaking of urine Bleeding with intercourse
M-S	Muscle aches	Joint aches	
Skin/Breast	Skin rashes	Breast pain	Breast discharge
Neurologic	Headache Fainting	Seizures Weakness	Numbness
Psychiatric	Depression	Anxiety	
Endocrine	Heat intolerance Night sweats	Cold intolerance	Hot flashes
Heme/Lymph	Easy bruising	Swollen glands	
Immun/Allergy	Seasonal allergies	Fevers	Chills

☐ Check here if none of the above apply.

BONNER GENERAL HEALTH
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