ROCHESTER GYNECOLOGIC AND OBSTETRIC ASSOCIATES, P.C.
MEDICAL HISTORY UPDATE

Welcome back to RGOA. We would like to update any relevant changes to your health history that may have occurred since your last annual or comprehensive visit. Please take a few minutes to complete this form and give the form to your physician.

Name_______________________________________DOB________________Today's Date_______________

Primary Care Physician_________________________Marital Status: (Circle) S M Sep D W Female Partner

Current Occupation_________________________________

Do You Have Additional GYN Complaints Today?: (Please circle all that apply)

1. Urinary problems
2. Difficulty getting pregnant
3. Problems with periods
4. Menopausal symptoms
5. Contraceptive advice
6. Planning pregnancy
7. Problems with intercourse
8. Abnormal bleeding
9. Unusual discharge
10. Other____
11. Breast mass
12. Pain
13. Difficult PMS
14. No problems

GYN History Last Menstrual Period_______________________

Your current method of birth control is:_______________________ No current need______ Sterilization_______________

Have you been pregnant since your last visit? YES____ NO ____ Are you sexually active at present? YES____ NO____

Periods come every _____ days and last for _____days. Periods are ❑ regular ❑ irregular ❑ light ❑ moderate ❑ heavy.

Do you have cramps with your period? YES___ NO___ If yes, what do you do for the discomfort_______________________

Do you bleed between periods? YES___ NO___ Do you ever use tampons? YES___ NO___

Medical History Changes

Have you been treated for any **NEW** conditions/problems **since your last yearly checkup**? _____NO ____YES

Please Specify:____

____

Family History

Has anyone in your family developed any **NEW** diseases or **died within the last year**? _____NO ____YES

Please Specify:____

____

Surgical Procedures and/or Hospitalizations SINCE Your Last Annual Examination (i.e., NEW occurrences)

Month/year	Procedure/ Reason for Hospitalization

Your Other Health Care Doctors Are: (please list all but **not** your dentist)

______________________________ ______________________________ ______________________________

______________________________ ______________________________ ______________________________

Your Current Medications Are: (please list all by **NAME AND DOSAGE** including vitamins, herbs, birth control)

______________________________ ______________________________ ______________________________

______________________________ ______________________________ ______________________________

______________________________ ______________________________ ______________________________

PLEASE TURN PAGE OVER

Patient Name____**DOB**____________**Today's Date**____________

Allergies: (Food, Medications, Latex) – **LIST NAME AND REACTION**: ❑ No known allergies

____

____

Review of Health Systems: Are you **CURRENTLY** having problems with any of the following:

CONSTITUTIONAL:

Weight gain -more than 10 lbs.	NO	YES
Weight loss -more than 10 lbs.	NO	YES
Marked fatigue	NO	YES
Night sweats	NO	YES

HENT:

Sinus problems	NO	YES
Headaches	NO	YES
Hearing loss	NO	YES
Nose bleeds	NO	YES

BREASTS/SKIN:

Breast pain	NO	YES
Breast lumps	NO	YES
Nipple discharge	NO	YES
Change in skin color	NO	YES

CARDIOVASCULAR:

Chest pain	NO	YES
Irregular heart beat	NO	YES
Fainting spells	NO	YES
Swelling of feet or ankles	NO	YES

RESPIRATORY:

Chronic cough	NO	YES
Frequent cough	NO	YES
Shortness of breath	NO	YES

GASTROINTESTINAL:

Difficulty swallowing	NO	YES
Frequent diarrhea	NO	YES
Frequent constipation	NO	YES
Blood in stool	NO	YES

GENITOURINARY:

Frequency	NO	YES
Urgency	NO	YES
Pain with urination	NO	YES
Incontinence	NO	YES

NEUROLOGICAL:

Lightheadedness	NO	YES
Dizziness	NO	YES
Numbness/tingling in extremities	NO	YES
Problems with coordination	NO	YES
Tremors	NO	YES

MUSCULOSKELETAL:

Joint stiffness or swelling	NO	YES
Weakness in muscles	NO	YES
Muscle pain	NO	YES
Joint pain	NO	YES
Back pain	NO	YES

PSYCHIATRIC:

Depression	NO	YES
Anxiety	NO	YES

Please Indicate Your Current Use And/or Status of the Following (Type & Frequency)

Health Habits:

Cigarettes: Never Smoked______ Quit (year)____ Current # cigarettes/day_____

Alcohol: None______ # drinks per week (beer, wine, liquor) ___________________ More than 2 drinks/day______

How many drinks does it take to feel an effect (to feel high)?___________

Have people annoyed you by criticizing your drinking? ❒ No ❒ Yes

Have you ever felt that you ought to cut down on your drinking? ❒ No ❒ Yes

Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover? ❒ No ❒ Yes

Caffeine: ______cups per day

Have you used illegal drugs in the last year? YES____ NO_____

Do you exercise? YES_____ NO_____If yes, amount and type____

Seatbelt use: Never_____ Occasionally____ Always_____

Calcium servings in diet per day:______________________________ Supplements per day_______mg.

Are you being physically, sexually or emotionally abused? YES_____ NO_____

Last full physical with internist or family practitioner: Year________

Last tetanus shot (this is good for 10 years): Month/Year________

Have you had any of the following screening tests **SINCE YOUR LAST VISIT**:

Colonoscopy Month/Year__________

DEXA Scan Month/Year__________

Mammogram Month/Year__________

Do you perform monthly self breast examinations: YES______ NO______

Are you interested in HIV (AIDS) testing? YES______ NO______

Were you born between 1945 and 1965? Are you interested in Hepatitis C Testing? YES_____ NO_____ (Rev. 12/13)