Annual Medical History Update

Today's date _____ Appointment date _____

Name: _____ Date of Birth: _____
(First) (Middle) (Last)

Primary Care Physician: _____

What are your primary concerns today? _____

CURRENT MEDICATIONS: (List all medications, even over the counter, vitamins, herbal remedies, etc. Include the following information regarding your medications. You may use additional pages if necessary. Also, please bring all your medications with you to your appointment.)

Medication	Strength	How Often	Prescribed By	Reason

Please list known allergies and reactions to medications or substances (e.g., latex, iodine, etc.)			
☐ No Known Allergies		Allergy	Reaction
Allergy	Reaction	Allergy	Reaction

Please list any surgeries since you were last seen here at Southdale OB/Gyn

Surgery/Reason	Date

Please list any *new* Medical Problems since you were last seen here at Southdale OB/Gyn

Medical Problem	Date of onset

Reproductive History

Menses duration (Number of days of bleeding):	Cycle Interval (Number of days from start to start):
Number of Tampons/day:	Flow (Light, Medium, or Heavy):
Last Menstrual Period: / / (Date)	Number of Pads/day:
Menopause Status (Pre, Peri or Post):	Certain of Last Menstrual Period Date (yes or no)?
Method of Birth Control:	
Bleeding between periods (yes or no):	Clots (yes or no)?

Social History

Drug	Never	Current	Former
		Amount used	*Age started/Age stopped*
Alcohol			
Caffeine			
Tobacco			
Street/Recreational Drugs			

Partner / Spouse Drug Use? ☐ Yes No ☐

Have you been sexually, physically, emotionally abused, threatened or hurt by anyone? ☐ Yes No ☐

Any new sexual partners? ☐ Yes No ☐

Any marital/family/social changes you would like us to know about?

_____