YEARLY HISTORY UPDATE

Welcome to Women's Specialists of New Mexico. Please complete the following questions to allow us to provide you with the best health care. If you do not understand any question or do not want to answer any question, leave it blank. All answers will be confidential and will be reviewed with your provider.

Name:___________________________ Age:__________ Date of Birth:___________

Occupation:_________________ Marital Status:______________ Contact Phone:__________

What is the main purpose of your visit today? ☐ Annual ☐ Problem______________________ ☐ Both

Name of family physician:______________________________Date last seen:___________

Do you have advanced directives? ☐ Yes ☐ No Would you like a chaperone? ☐ Yes ☐ No

Since your last visit with us, have any of these tests been performed?

☐ Blood Count ☐ Thyroid Testing ☐ Cholesterol/Lipid ☐ Bone Density Study ☐ Sigmoidoscopy/colonoscopy

Were any other tests performed?____

Were any test results abnormal?____

First day of last menstrual period:			Family history of:		
Date of last pap smear:			Yes	No	Diabetes
Date of last mammogram:			Yes	No	Heart attack/Stroke
What is your current method of birth control?			Yes	No	Breast cancer
Yes	No	Are you interested in a different method?	Yes	No	Ovarian cancer
Yes	No	Have your periods changed in the last year?	Yes	No	Colon cancer
Yes	No	Do you perform self-breast exams?	Yes	No	Osteoporosis
		How often?	Yes	No	Other cancers

Do you have any problems with the following? (list problems in space provided)		
Yes	No	☐ Weight loss ☐ gain ☐ skin changes ☐ fatigue ☐ headache ☐ depression ☐ anxiety
Yes	No	☐ Head ☐ ears ☐ eyes ☐ nose ☐ throat
Yes	No	Lungs or breathing
Yes	No	Heart or chest pain
Yes	No	Kidneys, bladder or urination
Yes	No	Stomach or intestinal

Yes	No	Have you been pregnant since your last visit?
Yes	No	Are you exercising on a regular basis?
Yes	No	Is your diet nutritionally balanced?
Yes	No	Are you currently smoking?
Yes	No	Do you feel alcohol or drugs are a problem for you?
Yes	No	Have you had a new sexual partner since your last visit?
Yes	No	Do you have any concerns about sexual relations?
Yes	No	Do you want to be tested for sexually transmitted infections?
Yes	No	Have you had a recent major stress: ☐ loss of job ☐ loss of loved one ☐ change in marital status ☐ Other:
Yes	No	Within the last year, have you been emotionally or physically abused?
Yes	No	Have you been hospitalized, had surgery or been injured since your last visit? Please list:
		Date: Reason:

List all current medical diseases/conditions:
List all **MEDICATIONS** you are taking (include herbs, vitamins and over-the-counter medications):
List any known **DRUG ALLERGIES** with reaction (i.e. hives, rash, vomiting)**:**

Please list any other concerns or comments:________________________________

Name:_______________________ DOB:__________ Date:__________

Provider's Initials
MD, CNM, NP, PA