

ANNUAL / INTERVAL UPDATE

Orange Coast Women's Medical Group, Inc. (949)829-5500

Today's Date: _____

Patient Name: _____ Birth Date: _____ Account # _____

Important: In order to provide the highest quality of health care possible, it is important that we have the following information. Please answer all of the doctor's questions as accurately as possible. If you do not understand the question please ask for assistance. Thank you.

Please describe the reason(s) for this visit: _____

Please explain any changes to your health since your last visit: _____

Drug allergies: _____

List any medications you are taking, including non-prescription drugs, vitamins, and herbals: _____

Female Genitourinary (Please Complete):

Date of last pap smear? _____ Any problem w/leaking urine? no yes
Any abnormal pap smears? no yes
Date of last mammogram _____ Are you sexually active? no yes
Result of mammogram normal? no yes Do you have pain w/intercourse? no yes
Date of last bone density test _____ Bleeding between periods? no yes
Result on bone density normal? no yes Vaginal discharge/itching? no yes
Bleeding after intercourse? no yes

Menstrual History:

Age period began: _____ Average # of days: _____ Do you use hormones? no yes
Date of last period: _____ Method of contraception: _____ If so, type: _____
Frequency of periods _____ Satisfied with this method? no yes Any vaginal bleeding? no yes

Past Medical History: Check here if no changes since last visit

Have you ever had the following:
Diabetes no yes Thyroid dysfunction no yes Infertility no yes
Hypertension no yes Major accidents no yes Mitral Valve Prolapse no yes
Heart Dz/High Chol no yes Stomach/Intestinal no yes Cancer no yes
Obesity no yes Tuberculosis no yes Anemia no yes
Kidney dysfunction no yes Asthma no yes Glaucoma no yes
Mental disorder no yes Herpes no yes AIDS or HIV+ no yes
Hepatitis/Liver dz no yes Anesthetic complication no yes

Past Surgical History: Check here if no changes since last visit

Have you ever had the following:
D & C no yes Cryosurgery no yes
Hysterectomy no yes Breast biopsy no yes Colposcopy no yes
Surgery on tubes/ovaries no yes Breast cyst aspiration no yes LEEP/Cone biopsy no yes
Cesarean delivery no yes Mastectomy no yes Urologic no yes

Please list any other previous surgeries or any other major illnesses and dates: _____

Obstetrical History (Please Complete):

Year	Wt.	Sex	#wks pregnant	Duration of Labor	C-section?	Complications?
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____

Social History (Please Complete):

Occupation: _____ Marital Status: S M W D

Do you exercise? no yes Have you ever been sexually abused? no yes

Type: _____ Have you ever felt physically or emotionally threatened? no yes

How often? _____ Do you get calcium in your diet? no yes

Smoking (type & amount per day) _____ Supplements: _____

If former smoker, date quit: _____ Alcohol (type and amount per week): _____

Do you use marijuana, cocaine or other drugs? _____

Family Medical History: *Check here if no changes since last visit*

Medical Problem	Family Members Affected	Choices: Mother, Father, Sibling, Grandmother, Grandfather
High Cholesterol	<input type="checkbox"/> No <input type="checkbox"/> Yes	Who: _____
Heart Disease	<input type="checkbox"/> No <input type="checkbox"/> Yes	Who: _____
High Blood Pressure	<input type="checkbox"/> No <input type="checkbox"/> Yes	Who: _____
Breast cancer	<input type="checkbox"/> No <input type="checkbox"/> Yes	Who: _____
Melanoma	<input type="checkbox"/> No <input type="checkbox"/> Yes	Who: _____
Diabetes	<input type="checkbox"/> No <input type="checkbox"/> Yes	Who: _____
Ovarian cancer	<input type="checkbox"/> No <input type="checkbox"/> Yes	Who: _____
Stroke	<input type="checkbox"/> No <input type="checkbox"/> Yes	Who: _____
Blood disorder	<input type="checkbox"/> No <input type="checkbox"/> Yes	Who: _____
Depression	<input type="checkbox"/> No <input type="checkbox"/> Yes	Who: _____
Colon cancer	<input type="checkbox"/> No <input type="checkbox"/> Yes	Who: _____
Osteoporosis	<input type="checkbox"/> No <input type="checkbox"/> Yes	Who: _____

Review of Systems (Please Complete):

Do you have now or have you had within the past year:

Const Weight Gain/Loss	<input type="checkbox"/> no <input type="checkbox"/> yes	CV History of heart attack...	<input type="checkbox"/> no <input type="checkbox"/> yes	Psych Depression	<input type="checkbox"/> no <input type="checkbox"/> yes
GI Bloody stools.....	<input type="checkbox"/> no <input type="checkbox"/> yes	History of blood clots		Skin Painful breasts	<input type="checkbox"/> no <input type="checkbox"/> yes
Abdominal pain	<input type="checkbox"/> no <input type="checkbox"/> yes	in legs or lungs	<input type="checkbox"/> no <input type="checkbox"/> yes	Breast lumps.....	<input type="checkbox"/> no <input type="checkbox"/> yes
Date of last colonoscopy _____		Neuro Seizures	<input type="checkbox"/> no <input type="checkbox"/> yes	Nipple discharge	<input type="checkbox"/> no <input type="checkbox"/> yes
Endo Night sweats	<input type="checkbox"/> no <input type="checkbox"/> yes	History of stroke	<input type="checkbox"/> no <input type="checkbox"/> yes	Other _____	
Hot flashes.....	<input type="checkbox"/> no <input type="checkbox"/> ye	History of migraines.....	<input type="checkbox"/> no <input type="checkbox"/> yes	_____	
Heme Bruising easily	<input type="checkbox"/> no <input type="checkbox"/> yes	Resp History of asthma	<input type="checkbox"/> no <input type="checkbox"/> yes	_____	

I VERIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

X _____
Signature of patient or parent if minor

_____ Date