



**RETURN VISIT  
HEALTH HISTORY UPDATE**

ACCOUNT NO.  
MED. REC. NO.  
NAME  
BIRTHDATE

**Name:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **Primary Care Provider:** \_\_\_\_\_  
Last First Middle

**Date:** \_\_\_\_\_ **Referring Provider:** \_\_\_\_\_

Why are you coming to the Center today? \_\_\_\_\_

What issues do you hope to discuss today? \_\_\_\_\_

**Interval History Since Your Last Visit.**

New Health Problems / Surgeries since last visit: \_\_\_\_\_

New Important Family History: \_\_\_\_\_

New Social Circumstances / Habits: \_\_\_\_\_

**Gynecologic / Obstetric History**

Contraception? \_\_\_\_\_ Tubal? \_\_\_\_\_ Vasectomy? \_\_\_\_\_

Date of last menstrual period \_\_\_\_/\_\_\_\_/\_\_\_\_

How many days from start to start of periods (average)? \_\_\_\_\_

How long do periods last? \_\_\_\_\_

Bleeding between periods? Yes  No

Bleeding after menopause? Yes  No

Are periods too heavy/too painful? Yes  No

Are you sexually active? Yes  No

With: Man  Woman

New sexual partner in the last year? Yes  No

History of sexual or physical abuse? Yes  No

Current sexual or physical abuse? Yes  No

Number of pregnancies \_\_\_\_\_

Vaginal deliveries \_\_\_\_\_

C-sections \_\_\_\_\_

Miscarriages \_\_\_\_\_

Abortions \_\_\_\_\_

**HPV risk:**

Number of lifetime sexual partners:  
less than 5  5 or more

Date of Last Pap: \_\_\_\_/\_\_\_\_/\_\_\_\_

History of abnormal Pap smears? Yes  No

History of sexually transmitted infections? Yes  No

If so, type(s) \_\_\_\_\_

Do you perform self breast exams? Yes  No



OC1202



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Patient Identification

**Social history and habits:**

Single  Partnered  Married  Divorced / separated  Widowed

Do you work outside the home? Yes  No

What is your occupation? \_\_\_\_\_

Do you have children? Yes  No  Ages \_\_\_\_\_

Do you exercise? Yes  No  Type/frequency \_\_\_\_\_

Alcohol use: Yes  No  Amount per day/week \_\_\_\_\_

Tobacco use: Yes  No  Past use:  Yes  No  
# cigarettes per day \_\_\_\_\_ Age began \_\_\_\_\_ Age quit \_\_\_\_\_

Drug use: Yes  No  Type: \_\_\_\_\_

**Do you have any of the following symptoms currently? ( Check and circle or underline)**

- Abdominal or pelvic pain
- Constipation / diarrhea / blood in stool
- Heartburn / trouble swallowing
- Urine leakage
- Vaginal / vulvar itching, irritation, discharge
- Breast lumps / nipple discharge
- Chest pain
- Shortness of breath
- Do you have sexual concerns
- Visual / hearing problems
- Weight loss, fevers, chills, sweats
- Headaches – migraine or tension
- Numbness / tingling / weakness of extremities
- Joint / muscle pain
- Depression, anxiety, irritability, trouble sleeping
- Hot flashes / vaginal dryness
- Is intercourse painful?
- Other concerns? \_\_\_\_\_

**Screening/Health Maintenance Especially Since Your Last Visit.**

**RESULT**

	Date of last testing, evaluation	RESULT	
		Normal	Abnormal
Pap Smear			
Mammogram			
Bone Density Exam			
Cholesterol Test			
Diabetes Test			
Thyroid Test			
Colon Cancer Screening			
Stool cards			
Flexible sigmoidoscopy			
Colonoscopy			
Barium enema			

Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_