

ANNUAL HEALTH UPDATE

NAME: _____ DATE: _____

To assist us in keeping your medical history up-to-date, would you please answer the following questions?

1. Has there been any change in your periods? YES NO

If yes, please describe: _____

2. Are you using any birth control? YES NO

If yes, what type: _____

3. Have you had any illnesses? YES NO

If yes, please describe: _____

4. Have you had any surgeries since your last exam? YES NO

If yes, please describe: _____

5. Have you seen any of your other doctors? YES NO

If yes, who have you seen: _____

6. What medications are you taking? _____

7. Cigarettes _____ per day Alcohol _____ Drug use

8. If you are over the age of 39, when did you have the following test:

Mammogram _____ Cholesterol _____ Stool test: _____

9. Please indicate the first day of your last period: _____

10. If there are any significant changes in your family history, please list: _____

PLEASE LIST YOUR CURRENT NAME, ADDRESS AND PHONE NUMBER

Name: _____

Phone numbers

Address _____

Home: _____

City, State, Zip: _____

Work: _____

Email Address: _____

Due to enactment of the Clean Claims Act, we have disclosure of any other health benefit plans. Please note below if you have more than one insurance plan.

I only have coverage under one insurance plan. _____

Date: _____

Signed: _____