ANNUAL HEALTH UPDATE

Name: _____ Date: _____

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

1. Has there been any change in your periods? ☐Yes ☐No
   If yes, please describe: _____
   Please indicate the first day of your last period? _____

   If your periods are heavy and impacting the quality of your life, would you like information on a simple, safe procedure in our office that can significantly reduce or eliminate your monthly periods? ☐Yes ☐No

2. Are you using any birth control? ☐Yes ☐No If yes, what type: _____

   Would you like information on a gentle, hormone-free permanent birth control procedure performed in the comfort of our office? ☐Yes ☐No

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 other doctors? ☐Yes ☐No
   If yes, who have you seen? _____

6. What medications/supplements are you taking?

   _____

   _____

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

   _____

10. Please list any concerns/issues that you would like to discuss today: _____

_____

11. Would you like more information on the additional services we offer such as spa services, dietary supplements or physician supervised weight loss? ☐Yes ☐No

Has there been any change in your contact information? ☐Yes ☐No

Name: _____ Cell Phone: _____
Address: _____ Home Phone: _____
City, State, Zip: _____
Email Address: _____

May we leave a detailed message on voicemail? Yes _____ No _____

Due to enactment of the Clean Claims Act, we must 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. ☐Yes ☐No

If No, please list all applicable health insurance policies. _____

_____

Date: _____ Signature: _____