Fair Oaks Women's Health
Convenience • Caring • Cutting-Edge

PATIENT INFORMATION UPDATE FOR WW EXAM

This form is to update our records since your last visit here. People move, pharmacies change, phone numbers change, so please complete this form. Sometimes it is urgent that we contact you, so please be as complete and accurate as possible, especially with phone numbers. Full voicemail boxes are a problem, please make room in yours in case we need to reach you. Thank you very much. All information provided is completely confidential.

DATE TODAY _____

PATIENT LAST NAME _____ FIRST NAME_____ M.I. _____

PREFERRED FIRST NAME _____ PREVIOUS NAME _____

ADDRESS _____ (PO Boxes Not Allowed)

CITY _____ STATE_____ ZIP _____

EMAIL _____ DOB: _____ MARITAL STATUS _____

SEXUAL ORIENTATION _____ GENDER IDENTITY _____

SEX AT BIRTH _____ PRONOUN ___she/her ___they/them ___he/him

PHONE NUMBERS _____ No Changes

HOME PH# _____ MOBILE PH# _____ WORK PH# _____

PREFERRED PH# WEEKDAYS (**circle** one): **HOME** **MOBILE** **WORK**

*Is your voice mail set up? Is your mailbox full? This means we may be unable to leave a message.

EMPLOYMENT

ARE YOU EMPLOYED? ____ If yes, EMPLOYER NAME _____

EMPLOYER PH. # _____ FAX # _____

PHARMACY INFORMATION

PHARMACY NAME: _____

PHARMACY ADDRESS: _____

PHARMACY CITY,STATE,ZIP _____ PH# _____

PRIMARY CARE DR. (PCP – FIRST AND LAST NAME)_____

EMERGENCY CONTACT INFORMATION (other than your spouse/partner)

CONTACT NAME _____ RELATIONSHIP _____

MOBILE PH# _____ OTHER PH# _____

Fair Oaks Women's Health
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INTERVAL HISTORY FORM

This form helps to keep us up to date with your health.
All your medical information is kept strictly confidential. Thank you.

Name: _____ **Date:** _____

Date of Birth: _____ **email:** _____

1st day of Last Period (LMP):_____ **Birth Control Method:** _____

Current Medication, Vitamins, Supplements: _____

_____

Since your last visit, have you had surgery or been diagnosed with a new condition?

Explain:_____

_____

Current: Smoking: _____ **Alcohol:** _____

Exercise (type and how often):_____

Colonoscopy (ever? last one when?): _____

Bone Density (ever? last one when?): _____

Mammogram (ever? last one when?): _____

Primary Care Provider: (first and last name please): _____

FAMILY HISTORY (enter CHANGES since your last exam)

Please indicate any major health conditions affecting (or affected) any close family members. Examples of major conditions are cancer, heart disease, high blood pressure, stroke, high cholesterol, thyroid disease, osteoporosis, mental illness, auto-immune diseases or any genetic or inheritable condition. Note if they have passed, at what age were they?

Mother or Father: _____

Sisters or Brothers: _____

Your biological children: _____

Grandparents (which side): _____

Aunts or Uncles: _____

Details: _____

_____

_____

REVIEW OF SYSTEMS

(Are you currently experiencing any of the following symptoms <u>to a significant degree</u>?)

General
- ____ Fatigue or Weakness
- ____ Fever, Chills or Sweats
- ____ Unexplained weight gain or loss

Skin
- ____ Lesions, Moles or Sores
- ____ Rash

Eyes, Ears, Nose and Throat
- ____ Sore Throat
- ____ Trouble Swallowing
- ____ Vision or Hearing Changes
- ____ Nose Bleeds

Breasts
- ____ Breast Lump or Lumps
- ____ Breast Pain or Tenderness
- ____ Nipple Discharge (other than white)

Cardiovascular
- ____ Chest Pain or Tightness
- ____ Irregular Heartbeat or Palpitations

Respiratory
- ____ Chronic Coughing
- ____ Shortness of Breath or Wheezing

Gastrointestinal
- ____ Heartburn
- ____ Nausea or Vomiting
- ____ Diarrhea (watery stool)
- ____ Severe Constipation
- ____ Abdominal Pain
- ____ Rectal Bleeding

Urinary
- ____ Burning with Urination
- ____ Urgency and/or Frequency of Urination
- ____ Leakage of Urine
- ____ Waking at night 2 or more times to urinate

Gyn (also see Menstrual History ahead)
- ____ Genital sores, lesions or bumps
- ____ Irregular periods
- ____ Bleeding Between Periods
- ____ Pain Before or During Periods
- ____ Vaginal Itching, Burning or Dryness
- ____ Vaginal Discharge
- ____ Vaginal Dryness
- ____ Pain during intercourse
- ____ Vulvar Pain
- ____ Severe PMS Symptoms

Endocrine (Glandular)
- ____ Menopause Symptoms (hot flashes)
- ____ Intolerance to Heat or Cold
- ____ Low Sex Drive
- ____ Excessive Hair Loss
- ____ Excessive Hair Growth

Musculoskeletal
- ____ Joint Pain (Back, Knee, Wrist, Hip)
- ____ Joint Swelling
- ____ Muscle Cramping or Pain

Hematologic
- ____ Swollen Glands
- ____ Easy/Frequent Bruising

Neurologic
- ____ Dizziness
- ____ Headaches
- ____ Numbness
- ____ Memory Problems

Psychiatric
- ____ Excessive Anxiety, Worries, Stress
- ____ Severely Depressed
- ____ Insomnia

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