**ESTABLISHED PATIENT ANNUAL FORM**

**Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Age**: \_\_\_\_\_\_\_\_\_\_ **Today’s Date** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date of Birth** \_\_\_\_\_\_\_\_\_\_\_ **Occupation**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Primary Care Provider**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Concerns for Today’s visit** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**First day of last period** \_\_\_\_\_\_\_\_\_ **Are your periods regular?** \_\_\_\_\_\_\_ **How far apart are they? Every** \_\_\_\_\_\_ **days**

**Current Birth Control** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **List all Meds & Supplements**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Review of Health** | | | | | **YES** | **NO** |
| Planning to be pregnant in the next year? | | | | |  |  |
| Requesting STD Testing? | | | | |  |  |
| New Allergies? | | | | |  |  |
| New Family History? | | | | |  |  |
| New Medical Issues? | | | | |  |  |
| Problem with Bladder Leakage? | | | | |  |  |
| Abnormal Vaginal Discharge? | | | | |  |  |
| Pain with Periods? | | | | |  |  |
| Vaginal Dryness? | | | | |  |  |
| PMS Symptoms? (Mood, Bloat, Sleep) | | | | |  |  |
| Text while driving? | | | | |  |  |
| Smoking? (Tobacco or other) | | | | |  |  |
| Recreational Drug? | | | | |  |  |
| Alcohol more than 4 oz/Day? | | | | |  |  |
| Wearing seatbelt? | | | | |  |  |
| Wearing helmets, life jackets, etc.? | | | | |  |  |
| Exercising at least 3 times/week? | | | | |  |  |
| Happy with Sex drive/Libido? | | | | |  |  |
| Happy with your sexuality/sexual identification? | | | | |  |  |
| Pain with Sex? | | | | |  |  |
| Vaccines current with: | Flu |  | HPV |  | tDAP |  |
| Screening Labs |  | | VitD | |  | |

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| **Constitutional:** | Chills, Fatigue, Fever, Weight-change |  |
| **EYES**: | Blurred vision, Eye pain, Light sensitivity |
| **E/N/T:** | Hearing problem, Congestion, Bloody nose, Hoarse voice |
| **Heart:** | Chest pain, Palpitations, Racing heart, Body swelling |
| **Lungs:** | Cough, Difficulty breathing |
| **GI:** | Abdominal pain, Heartburn, Constipation, Diarrhea, Stool changes |
| **Musculoskeletal:** | Pain in - Neck, Back, Joints, Arms or Legs |
| **Skin:** | Atypical moles, Nail fungus, Rash, Itchy skin |
| **Breast:** | Mass, Skin changes, Size changes, Tenderness, Nipple discharge |
| **Neuro:** | Headaches***,*** Memory changes,Balance problem, Dizziness |
| **Hem/Lymph:** | Easy bruising, Easy bleeding, Lymph gland swelling |
| **Endocrine:** | Hair loss, Heat/cold tolerance, Water/Food craving |
| **Allergic:** | Seasonal, Frequent illness, HIV exposure |
| **Psychiatric:** | Anxiety, Mood swings, Difficulty concentration, Depression |
| **Any other symptoms you wish to explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | |

**For Medical staff use only**

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| **Last Annual** | **Last PAP** | **Last Mammogram** | **Colonoscopy** | **DEXA** | **Chaperone** |
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