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Annual Update Form

Name: _____ Date of birth: _____ Age: _____

Primary care physician: _____ Specialists: _____

What is the reason for your visit today? _____

Preferred pharmacy: name _____ location _____

Last menstrual period _____

Last mammogram _____ Last Pap smear _____ Last bone density scan _____

Are you sexually active with: ☐1 partner ☐ multiple partners ☐men ☐ women ☐ men and women ☐ none

What do you use for birth control? _____

Have you been physically hurt by your partner or ex-partner? ☐ Yes ☐ No

Have you been emotionally abused by your partner or ex-partner? ☐ Yes ☐ No

Over the past 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	Over half the days	Nearly every day
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

AT THIS TIME, do you have any of the following symptoms? Please check all that apply.

General
□ Hot flashes
□ Night sweats
□ Unusual fatigue

Eye/ear/nose/throat
□ Hearing loss

Respiratory
□ Shortness of breath

Cardiovascular
□ Chest pain
□ Heart palpitations

Gastrointestinal
□ Abdominal pain
□ Constipation
□ Diarrhea
□ Heartburn

Genitourinary
□ Urinary incontinence

Reproductive
□ Vaginal dryness
□ Pain with sex
□ Decreased libido
□ Vaginal discharge
□ Irregular periods
□ Heavy periods
□ Menstrual cramps

Breast
□ Breast tenderness
□ Breast lumps
□ Nipple discharge

Dermatologic
□ Hair loss

Neurological
□ Severe headaches
□ Memory problems

Mental health
□ Anxiety
□ Depression
□ Insomnia
□ Suicidal thoughts

Metabolic/endocrine
□ Cold intolerance
□ Heat intolerance

Musculoskeletal
□ Joint pain
□ Joint swelling

Hematologic
□ Enlarged lymph nodes

Immunologic
□ Environmental allergies
□ Food allergies