



## Annual Exam Update

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Today's Date: \_\_\_\_\_

**THANK YOU for taking the time to answer these questions. Most insurance companies now require this information to be updated at every visit.**

1. Who is your primary care physician? \_\_\_\_\_

2. **All medication information is required before being seen by Physician.** Please list all current medications (name/dose/frequency).

<u>Medication</u>	<u>Dose</u>	<u>Frequency</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

3. When was your last menstrual period? \_\_\_\_\_

4. What is your current form of birth control? \_\_\_\_\_

5. Which year, if any, was your last Cholesterol Screening? \_\_\_\_\_ (Result): \_\_\_\_\_ Colorectal Screening? \_\_\_\_\_

6. Are you allergic to any medications?  YES  NO  None Known **IF YES, EXPLAIN:** \_\_\_\_\_

7. Have you had any serious illnesses, injuries, been hospitalized or have had any surgeries since your last appointment to our office?

YES  NO -- **Explain:** \_\_\_\_\_

8. How many pregnancies have you had? \_\_\_\_\_ How many children living? \_\_\_\_\_

9. Have you discovered any additional information about your family history that we should know?

YES  NO -- **Explain:** \_\_\_\_\_

10. Since your last annual visit, have you been diagnosed with any of the following?

Heart Disease	<input type="checkbox"/> YES	<input type="checkbox"/> NO	AIDS (HIV)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
High Blood Pressure	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Hepatitis	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Asthma	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Anemia or Blood Disorder	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Tuberculosis	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Blood Transfusion	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Diabetes	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Allergies	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Thyroid Disease	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Breast Problems	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Liver Disease	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Cancer	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Kidney or Bladder Problems	<input type="checkbox"/> YES	<input type="checkbox"/> NO	STD's	<input type="checkbox"/> YES	<input type="checkbox"/> NO

**IF YES, PLEASE INDICATE THE APPROXIMATE DATE OF DIAGNOSIS:** \_\_\_\_\_

**Do you:**

Smoke?:  YES  NO **(If YES, describe the amount)** \_\_\_\_\_

Drink alcohol?:  YES  NO **(If YES, describe the amount)** \_\_\_\_\_

Use Drugs?:  YES  NO **(If YES, please describe):** \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Significant Other