

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Patient No: \_\_\_\_\_

Physician: \_\_\_\_\_ Date of last menstrual cycle: \_\_\_\_\_

Chief Complaint/Main reason for today's visit: \_\_\_\_\_

Please list any physicians you would like to receive a report of today's visit: \_\_\_\_\_

## ESTABLISHED PATIENT HEALTH HISTORY UPDATE

### PAST MEDICAL HISTORY

Since your last visit to Lincoln Center OB-GYN, are you being treated for any new symptoms or diagnoses? Yes / No

If yes, please list: \_\_\_\_\_

Have you had any surgeries, procedures, or hospitalizations since your last visit? Yes / No

If yes, please list (include) location and dates: \_\_\_\_\_

### MEDICATION HISTORY

Have you acquired any new allergies since your last visit? Yes / No

If yes, please list: \_\_\_\_\_

Please list your medications (prescription and over the counter) with doses and frequency: \_\_\_\_\_

### REVIEW OF SYSTEMS

Have any family members been diagnosed with a significant medical problem? Yes / No

Please Elaborate: \_\_\_\_\_

Have there been any changes in your employment or home life? Yes / No

Please Elaborate: \_\_\_\_\_

### SINCE YOUR LAST VISIT, HAVE YOU HAD ANY OF THE FOLLOWING?

<b>CONSTITUTIONAL</b>	Circle One:	<b>GENITOURINARY</b>	Circle One:	<b>ENDOCRINE</b>	Circle One:
Weight loss	YES NO	Blood in urine	YES NO	Dry skin	YES NO
Weight gain	YES NO	Pain with urination	YES NO	Abnormal thirst	YES NO
Fever	YES NO	Urine loss when straining	YES NO	Hot flashes	YES NO
Fatigue	YES NO	Abnormal discharge	YES NO	Too hot/cold	YES NO
		Abnormal periods/bleeding	YES NO	Tired/sluggish	YES NO
<b>CARDIOVASCULAR</b>	Circle One:	Painful periods	YES NO	<b>NEUROLOGICAL</b>	Circle One:
Chest pain	YES NO	PMS	YES NO	Numbness/tingling	YES NO
Difficult breathing on exertion	YES NO	Painful intercourse	YES NO	Trouble walking	YES NO
Swelling of legs	YES NO	Problems getting pregnant	YES NO		
Palpitations of heart	YES NO	<b>MUSCULOSKELETAL</b>	Circle One:	<b>PSYCHIATRIC</b>	Circle One:
High blood pressure	YES NO	Muscle weakness	YES NO	Are you generally satisfied with your life?	YES NO
<b>RESPIRATORY</b>	Circle One:	Joint, neck, or back pain	YES NO	Depression	YES NO
Shortness of breath	YES NO			Frequent crying	YES NO
Chronic cough <i>more than 3 weeks</i>	YES NO	<b>GASTROINTESTINAL</b>	Circle One:	Do you hear voices?	YES NO
<b>HEMATOLOGIC/SKIN</b>	Circle One:	Frequent diarrhea	YES NO	Have you considered suicide?	YES NO
Frequent bruises	YES NO	Blood in stool	YES NO	Have you considered murder?	YES NO
Swollen glands	YES NO	Abdominal pain	YES NO		
		Indigestion/heartburn	YES NO	<b>BREAST</b>	Circle One:
		Nausea/vomiting	YES NO	Pain in breast	YES NO
		Constipation	YES NO	Nipple discharge	YES NO
				Lumps/masses in breast	YES NO

Patient Note Section –

*Please elaborate on any of the above as needed:*

PATIENT'S SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_

PROVIDER'S SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_