PATIENT MEDICAL UPDATE INFORMATION

Dear Patient: **Date** _____

Please assist us in providing you with the highest quality of medical care by answering and updating the information below as accurately as possible.

BP_____/_____ HR_____Weight _____ Height_____

G_____ P_____ A_____

Sincerely,

Dr Michele Beck & Staff

Please **Print** Your Name: _____
How Old are you today? _____

Are you here for your annual or yearly "Well Woman Visit" today? Yes / No

Do you have any specific problems, questions or concerns that you would like your doctor to discuss with you today? Yes No If yes please explain _____
_____
_____

If you are still having periods,
What date did your most recent period start? _____
How often do you get your periods (28 days, 32 days etc)? _____
How many days do your periods usually last? _____
How would you describe your flow? light / medium / heavy / or flooding
Was your most recent period normal for you? Yes / No

What Prescription Medicines are you currently taking? _____
_____
What Non-Prescription Medicines are you currently taking?_____
What Medicines are you allergic to? _____

Are You currently sexually active? Yes / No
If you are sexually active and are under age 50 what do you use for birth control? _____

When was your last Pap Smear?_____
If you are age 35 or older, when was your last mammogram? _____
If you are age 40 or older when were you last tested for blood in your stool? _____
If you are age 50 or older, when was your last bone density test? _____
If you are age 50 or older, when was your last colonoscopy? _____
When was the last time that your urine was tested? _____
When was the last time that you had a comprehensive blood profile? _____

Do you smoke? Yes / No If yes how many cigarettes or packs per day? _____

Have there been any changes in your medical history or medical condition since your were last seen in our office? Yes No It yes please explain _____
_____
Have you had any operations or surgical procedures since you were last seen in our office?
Yes No If yes please explain_____

Have you been the victim of sexual abuse or domestic violence? Yes No If Yes please explain _____
_____

Who is the name of your Internist / Family Physician or Primary Care Physician? _____
Have you seen your he/she within the past year? Yes/ No

If you have health insurance, indicate the name of your insurance company_____