PATIENT UPDATE FORM

**COMPLETE THE FIRST PAGE OF THIS FORM EACH VISIT**

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICATION LIST: (*include all prescription and non-prescription medications currently taking or have taken in last week)***

Include Name of Medicine, strength/dosage, and frequency or how often you take it (if more space is needed please bring list with you)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**ARE YOU ALLERGIC TO ANY MEDICATIONS? \_\_\_\_\_\_\_\_NO \_\_\_\_\_\_\_\_ YES (**If yes, please list below and indicate reaction that occurred)

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**NAME OF PHARMACY AND LOCATION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**REASON FOR VISIT:** (please check one)

\_\_\_\_\_ Wellness/Preventative Care

\_\_\_\_\_ Pregnancy Confirmation

\_\_\_\_\_ Gynecological visit / Problem today (please explain): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Referred by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last menstrual period: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**REVIEW OF SYSTEMS: (Please circle all that apply and give brief explanation if needed)**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Systemic** | None | Weight Change | Fever | Night sweats | Fatigue |
| **Sinus** | None | Sinus Pain | Congestion |  |  |
| **Head** | None | Headache | Eyes | Ears | Throat/Neck pain |
| **Breast** | None | Breast Pain | Nipple Discharge | Breast lump |  |
| **Chest** | None | Heart | Lungs | Cough |  |
| **GI** | None | Nausea | Vomiting | Abdominal Pain |  |
| **Genital Urinary** | None | Pain with urination | Loss of urinary control | Blood in urine | Genital lesion/sore |
| **Skin** | None | Skin rash | Mole | Sores |  |
| **Musculoskeletal** | None | Bone or joint pain | Muscle aches |  |  |
| **Endocrine** | None | Excessive sweating | Excessive thirst | Change in sex drive |  |
| **Psychological** | None | Sleep changes | Anxiety | Depression |  |
| **Neurological** | None | Dizziness | Seizures | Fainting |  |
| **Other** |  | | | | |

**CONTRACEPTION:** *(****Please check all that apply)***

\_\_\_\_\_\_ None \_\_\_\_\_ Attempting Pregnancy \_\_\_\_\_Birth Control Pills \_\_\_\_\_ IUD: (year inserted) \_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_ Natural Family Planning \_\_\_\_\_Condoms \_\_\_\_\_Contraceptive Ring \_\_\_\_\_ Contraceptive Implant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_ Menopause \_\_\_\_\_ Hysterectomy \_\_\_\_\_Tubal Ligation \_\_\_\_\_ Vasectomy

\_\_\_\_\_\_ Essure

Are you needing birth Control today? YES / NO Do you have a preference? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ONLY COMPLETE THE FOLLOWING IF CHANGES HAVE OCCURRED SINCE YOUR LAST VISIT**

(Initial if no change)

**MENSTRUAL HISTORY: \_\_\_\_\_ No changes**

Are your periods regular? YES / NO How often do you menstruate? Every \_\_\_\_\_\_\_days. How long do your periods last? \_\_\_\_\_\_\_\_\_\_\_\_days Number of pads or tampons soaked in 24 hours on the heaviest day of bleeding? \_\_\_\_\_\_\_\_\_ Cramps are Mild Moderate Severe No pain

Do you have spotting between your periods? YES / NO Do you have bleeding or spotting after intercourse? YES / NO Do you douche? YES / NO

**PREGNANCY HISTORY: \_\_\_\_\_ No changes**

Total # Pregnancies\_\_\_\_\_\_ Term Deliveries\_\_\_\_\_\_ Preterm Deliveries\_\_\_\_\_\_Miscarriages\_\_\_\_\_\_Abortions\_\_\_\_\_\_Ectopic\_\_\_\_\_\_Living children\_\_\_\_\_\_

List any problems related to pregnancy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SOCIAL HISTORY: \_\_\_\_\_ No changes**

Single \_\_\_\_\_ Married \_\_\_\_\_ Separated\_\_\_\_\_ Divorced\_\_\_\_\_ Widowed\_\_\_\_\_

**Tobacco Use**: **Alcohol Use**: YES / NO **Drug Use**: YES / NO **Sexually activity**:

**\_\_\_** Never a smoker \_\_\_Daily # glasses\_\_\_\_\_ \_\_\_Current use: \_\_\_\_\_\_\_\_\_\_\_\_\_ History of sexual activity: YES / NO

**\_\_\_**Former smoker \_\_\_Weekly:\_\_\_\_\_\_\_\_\_\_ \_\_\_Currently in Rehab Currently sexually active: YES / NO

\_\_\_Current every day smoker \_\_\_Monthly:\_\_\_\_\_\_\_\_\_ \_\_\_Former use # of partners in last year\_\_\_\_\_

\_\_\_Current someday # of partners in lifetime \_\_\_\_\_

# Per day\_\_\_\_\_\_\_\_\_(pks/cig)

**FAMILY HISTORY: \_\_\_\_\_ No changes**

**(Please indicate relationship of family member and whether paternal or maternal grandparent when applicable)**

High Blood Pressure\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Breast Cancer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diabetes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ovarian Cancer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Heart Disease\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Intestinal Cancer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Thyroid Disorder\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Blood Clotting Disorder\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL HISTORY: \_\_\_\_\_ No changes**

\_\_\_\_\_ High Blood Pressure \_\_\_\_\_Heart Disease / Failure \_\_\_\_\_High Cholesterol

\_\_\_\_\_ Diabetes \_\_\_\_\_Thyroid disorder \_\_\_\_\_Obesity

\_\_\_\_\_Allergies \_\_\_\_\_Asthma \_\_\_\_\_Emphysema

\_\_\_\_\_Acid Reflux \_\_\_\_\_Irritable Bowel Syndrome \_\_\_\_\_Colon Cancer

\_\_\_\_\_Urinary Tract Infection \_\_\_\_\_Kidney Disorder \_\_\_\_\_Kidney stones

\_\_\_\_\_Osteoarthritis \_\_\_\_\_Low Back pain \_\_\_\_\_Fibromyalgia

\_\_\_\_\_Headaches/Migraines \_\_\_\_\_Brain tumor \_\_\_\_\_Seizures

\_\_\_\_\_Epilepsy \_\_\_\_\_Anxiety disorder \_\_\_\_\_Bipolar Disorder

\_\_\_\_\_Depression \_\_\_\_\_PMS \_\_\_\_\_Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SURGICAL HISTORY:** **\_\_\_\_\_ No changes**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PAP SMEARS**

Your screening Pap smear could require a pathologist’s review. If a review is required, a cytology fee is automatically incurred and charged to the patient. This fee of $60 will not be covered under Wellness coverage, **but will** fall under non-routine medical benefits, and could be subject to deductible, co-pays, and coinsurance.

**HUMAN PAPILLOMA VIRUS TESTING (HPV)**

Human Papilloma Virus (HPV) is a common virus that affects both females and males. Most types are harmless, do not cause any symptoms, and resolve without treatment. Some are high risk and can cause cervical cancer or abnormal cells in the lining of the cervix that can sometimes turn into cancer.

If your pap smear shows atypical cells of undetermined significance (ASCUS), an HPV test for the High Risk subtypes may be ordered. If the results are negative, we will repeat your pap smear in one year. If the results are positive, we will call you into the office for additional testing.

HPV testing as a result of an abnormal pap smear will allow us to expedite testing and get results to you in a timely manner. There is an additional charge for HPV testing that is not covered under Wellness coverage, **but** will fall under non-routine medical benefits, and could be subject to deductible, co-pays, and coinsurance. The charge is approximately $100 for HPV testing and will be billed to your insurance.

By signing below, you acknowledge receipt of the information regarding possible cytology fees and HPV test fees and you acknowledge that you and/or your insurance may be charged if medically necessary.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name (PRINT)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Date

**PLEASE BRING COMPLETED FORM WITH YOU TO YOUR APPOINTMENT. YOU MAY ALSO FAX TO 601-936-1416 OR 601-936-3664.**

**For your convenience and compliance with medical legal requirements, East Lakeland OB-Gyn Associates provides our patients with On-line Patient Portal access. An invitation to the Portal will be sent to your email address that you provide us. Open the invitation and follow the link to complete the set up process. This will be your connection with your doctor and our staff to review test results, request prescription refills and ask questions concerning your care and health.**

**Thank you for choosing East Lakeland OB-Gyn Associates**