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)

_______________________________________ _______________________________________
_______________________________________ _______________________________________
_______________________________________ _______________________________________
_______________________________________ _______________________________________

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): ____
____
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:
___ Never a smoker
___Former smoker
___Current every day smoker
___Current someday
Per day_________(pks/cig)

Alcohol Use: YES / NO
___Daily # glasses_____
___Weekly:__________
___Monthly:_________

Drug Use: YES / NO
___Current use: _____________
___Currently in Rehab
___Former use

Sexually activity:
History of sexual activity: YES / NO
Currently sexually active: YES / NO
# of partners in last year_____
# of partners in lifetime _____

FAMILY HISTORY: _____ No changes
(Please indicate relationship of family member and whether paternal or maternal grandparent when applicable)

High Blood Pressure_______________________________
Diabetes _______________________________
Heart Disease_______________________________
Thyroid Disorder_______________________________
Breast Cancer: _______________________________
Ovarian Cancer _______________________________
Intestinal Cancer_______________________________
Blood Clotting Disorder_______________________________
Other: _______________________________

MEDICAL HISTORY: _____ No changes
_____ High Blood Pressure
_____ Diabetes
_____Allergies
_____Acid Reflux
_____Urinary Tract Infection
_____Osteoarthritis
_____Headaches/Migraines
_____Epilepsy
_____Depression
_____Heart Disease / Failure
_____Thyroid disorder
_____Asthma
_____Irritable Bowel Syndrome
_____Kidney Disorder
_____Low Back pain
_____Brain tumor
_____Anxiety disorder
_____PMS
_____High Cholesterol
_____Obesity
_____Emphysema
_____Colon Cancer
_____Kidney stones
_____Fibromyalgia
_____Seizures
_____Bipolar Disorder
_____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