FOR OFFICE USE ONLY: H_________W_________B_________P_________T_______O2 __________

Annual Update Form

Legal name: ______________________________ Preferred name (if different): __________________________

What is your gender identity? ▢ Female ▢ Transgender woman ▢ Transgender man ▢ Genderqueer/Non-binary ▢ Male ▢ Decline to state

What sex were you assigned at birth? ▢ Female ▢ Male ▢ Intersex ▢ Decline to state

What pronouns do you use? ▢ He/Him ▢ She/Her ▢ They/Them ▢ Ze/Hir ▢ Other______________

Primary Care Provider: ________________________ **Specialists:** ______________________________________

List all medications: Refill needed? Refill needed?

1. ______________________________ ▢
2. ______________________________ ▢
3. ______________________________ ▢
4. ______________________________ ▢
5. ______________________________ ▢
6. ______________________________ ▢
7. ______________________________ ▢
8. ______________________________ ▢

List all current supplements:

1. ____________________________________
2. ____________________________________
3. ____________________________________
4. ______________________________
5. ______________________________
6. ______________________________

Preferred Pharmacy: Name____________________ Address: ___________________________________

List any drug allergies (including type of reaction): ▢ None ___________________________________

List dates of immunizations:

Hepatitis A ________ Flu shot __________ Tetanus/Tdap __________ HPV ____________

Hepatitis B ________ Pneumonia ________ Shingles___________

Social History:

Occupation:____________________________

Have you used tobacco products: ▢ Yes ▢ No

How many per day:________________________

Number of years:_______Date quit:__________

Do you use drugs? ▢ Yes ▢ No

What type of drugs?______________________

Place of employment:________________________

Do you drink alcohol? ▢ Yes ▢ No Type:_______

How many drinks per week?_________________

History of alcohol abuse? ▢ Yes ▢ No

Have you ever felt the need to cut down? ▢ Yes▢ No

Have you ever felt guilty about drinking? ▢ Yes ▢ No

Marital status: ▢ Single ▢ Married ▢ Domestic partner ▢ Separated ▢ Divorced ▢ Widowed

Who do you live with?____

If you have children, what are their ages?____

Do you exercise? What type and how often?____

Nutrition: Is there anything unique about your diet, including foods that you avoid:_____________________

Do you have an advanced directive? ▢ Yes ▢ No

Do you have a Health care power of attorney? ▢ Yes ▢ No Name: ______________________________

New medical problems, surgeries, and injuries since last visit: _____________________________________

____

Preventive Care: Please list dates of screening tests if applicable.

Last pap smear: _____________ ▢ Normal ▢ Abnormal ____

Last mammogram: _________ History of abnormal mammogram? ▢ Yes ▢ No Results:________________

Bone density test: __________ Results: ▢ Normal ▢ Osteopenia ▢ Osteoporosis

Colonoscopy :_____________ Results: ▢ Normal ▢ Polyps ▢ Abnormal ___________________________

Family History:

List any changes in your family medical history since your last visit:______________________________________

____

Gynecologic history (if applicable):

Age when period started:________ Last menstrual period:_______________ ▢ Postmenopausal

Number of days between the first day of your period and the first day of your next period: _______________

Regular periods: ▢ Yes ▢ No Any recent changes in your periods?_________________________________

Number of pads/tampons used on heaviest day of flow:___ Menstrual cramps ▢ none ▢ mild ▢ mod ▢ severe

Pregnancy history (if applicable):

Total number of pregnancies:___ Number of living children:____ Number of ectopic pregnancies:___
Number of full-term births: ____ Number of adopted children:____ Number of abortions:____
Number of preterm births:____ Number of miscarriages:______

Sexual/relationship History:

Do you identify as: ▢ Straight or heterosexual ▢ Lesbian, gay, or homosexual ▢ Bisexual
▢ Pansexual ▢ Queer ▢ Don't know ▢ Decline to answer

What do you use for birth control (if applicable): ▢ birth control pills ▢ condoms ▢ IUD ▢ Diaphragm ▢ Nuvaring
▢ Nexplanon/Implanon ▢ Depo-Provera ▢ tubal ligation ▢ vasectomy ▢ Other______________

History of sexually transmitted infections? ▢ Yes ▢ No Explain:____________________________________

Do you wish to be screened for sexually transmitted infections? ▢ Yes ▢ No

Have you been physically hurt by your partner or ex-partner? ▢ Yes ▢ No

Have you been emotionally abused by your partner or ex-partner? ▢ Yes ▢ No

Do you currently have any of the following symptoms? Please check all that apply.

General: ▢ Chills ▢ Fatigue ▢ Fever ▢ Night Sweats ▢ Weight Gain ▢ Weight loss

Eye/Ear/Nose/Throat: ▢ Ear Drainage ▢ Ear Pain ▢ Eye Discharge ▢ Eye Pain ▢ Hearing Loss
▢ Nasal Congestion ▢ Runny Nose ▢ Sinus Pressure ▢ Sneezing ▢ Sore Throat
▢ Itchy Eyes ▢ Visual Changes

Respiratory: ▢ Cough ▢ Shortness of Breath ▢ Wheezing

Cardiovascular: ▢ Chest Pain ▢ Edema ▢ Palpitations

Gastrointestinal: ▢ Abdominal Pain ▢ Constipation ▢ Diarrhea ▢ Heartburn ▢ Loss of Appetite ▢ Nausea
▢ Vomiting

Genitourinary & Reproductive: ▢ Painful Urination ▢ Blood in Urine ▢ Awakening at Night to Urinate
▢ Urinary Frequency ▢ Urinary Incontinence ▢ Burning with Urination ▢ Lack of Periods ▢ Painful Periods
▢ Heavy Periods ▢ Irregular Periods ▢ Low Libido ▢ Pain with Sex ▢ Hot Flashes ▢ Vaginal Discharge
▢ Vaginal Dryness

Breast: ▢ Nipple Discharge ▢ Lumps ▢ Breast Pain

Dermatologic: ▢ Excessive Hair ▢ Hives ▢ Itching ▢ Changes in Moles ▢ Rash ▢ Skin Lesion

Neurological: ▢ Dizziness ▢ Numbness ▢ Weakness ▢ Gait Disturbance ▢ Headache ▢ Memory Loss
▢ Loss of Consciousness ▢ Seizures ▢ Tingling ▢ Tremors

Mental Health: ▢ Anxiety ▢ Depression ▢ Insomnia ▢ Suicidal Thoughts

Endocrine: ▢ Cold Intolerance ▢ Heat Intolerance ▢ Excessive Thirst

Musculoskeletal: ▢ Back Pain ▢ Joint Pain ▢ Joint Swelling ▢ Muscle Weakness ▢ Neck Pain ▢ Muscle Aches

Hematologic: ▢ Easy Bleeding ▢ Easy Bruising

Allergies: ▢ Contact Allergies ▢ Environmental Allergies ▢ Food Allergies ▢ Seasonal Allergies

PHQ:

Over the past 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

Eating disorder screening:

Are you satisfied with your eating patterns? ▢ Yes ▢ No

Do you ever eat in secret? ▢ Yes ▢ No

Does your weight affect the way you feel about yourself? ▢ Yes ▢ No

Have any members of your family suffered with an eating disorder? ▢ Yes ▢ No

Do you currently suffer with or have you ever suffered in the past with an eating disorder? ▢ Yes ▢ No