Mt Hood Women's Health, P.C. — Return Visit Health Update

Name: ____ **DOB:**___________ **Date:**_________________________

Reason for today's visit:____

New Health Problems/Surgeries since last visit: ____

____

New drug allergies since last visit: ____

New important family history since last visit: ____

Current Medications: Prescribed/Over the Counter/Supplements/Herbs

Medication/Dose	Medication/Dose	Medication/Dose
_______________________________	_______________________________	_______________________________
_______________________________	_______________________________	_______________________________

Gynecologic/Obstetric History

Current method of birth control: □ Tubal □Vasectomy □ Depo Injection □ IUD □ Pill □ Other: _______________

Do you use condoms? □ Yes □ No □ Sometimes

First day of last menstrual period: ____/____/________

Bleeding between periods? □ Yes □ No

Bleeding after menopause? □ Yes □ No

Heavy or painful periods? □ Yes □ No

Number of Pregnancies (include current) _________

Vaginal Deliveries __________

C-Sections __________

Miscarriages __________

Abortions __________

Are you sexually active? □ Yes □ No

With □ Man □ Woman □ Both

New sexual partner in the past year? □ Yes □ No

How long have you been with your partner?____

Date of last Pap Smear: ____/____/________

□ Normal □ Abnormal

Date of last mammogram: ____/____/________

□ Normal □ Abnormal

Tobacco Use? □ No □ Yes □ Quit

Amount per day/week: _______________________

Alcohol Use? □ No □ Yes

Amount per day/week: _______________________

Drug Use? □ No □ Yes Type:__________________

Amount per day/week: _______________________

Do you exercise? □ Yes □ No

Type/Frequency: _________________________

Do you have any of the following symptoms? Please circle which.

□ Abdominal/Pelvic Pain

□ Constipation/Diarrhea/Blood in Stool

□ Urine Leakage

□ Vaginal Itching, Irritation, or Discharge

□ Breast Lumps or Discharge

□ Sexual Concerns

□ Other: ____________________________

□ Unexplained Weight Loss/Gain

□ Frequent Headaches

□ Depression, Anxiety, Irritability, Trouble Sleeping

□ Hot Flashes/Vaginal Dryness

□ Painful Intercourse

□ Abnormal Bleeding

If deemed medically necessary and appropriate, do you consent to receive blood or blood products?

□ Yes □ No, I would like to participate in the Legacy Bloodless Surgery Program