Renee Hilliard, M.D.

Obstetrics and Gynecology

Annual Health History Update

Name ______________________________ Age ________ Date ____________

Marital Status ______________________ **Best Phone # to reach you** ______________________

Why are you here today? ____

Do you have any new medical concerns today? Y N ______________________________

____

Current medications: ____

Medication allergies: Y N ________________________________ Are you allergic to latex? Y N

Name of your primary / family physician ______________________________________

Menstrual Cycle History:

1st day of your last period ________________ Was it normal? Y N

Have you had a hysterectomy? Y N Are your periods regular? Y N

Do you have: Excessive bleeding Y N Mood Swings Y N

Pain / Cramps Y N Bleeding between periods Y N

Are you sexually Active? Y N Do you have pain with intercourse? Y N

What are you doing to prevent pregnancy? None Condoms Tubal Ligation IUD Vasectomy Ring

Depo-Provera Patch Abstinence Pills (fill in name) ______________ Other ____________

Are you happy with this method? Y N If no, would you like a different method? Y N

When was your last pap smear? ______________________ Were the results: Normal or Abnormal

Have you **ever** had an abnormal pap smear? Y N If yes, when ___________

Do you smoke? Y N If yes, how much? ________ Do you exercise? Y N Describe __________________

Are you having any urinary problems? Y N Explain ______________________________________

Are you having any problems with vaginal discharge? Y N Explain ____________________________

Have you had? Mammogram: Y N When __________ Bone density scan: Y N When __________

Colonoscopy: Y N When __________ Cholesterol checked: Y N When __________

Have there been any new medical problems (i.e. cancer) among your immediate family since your last visit? Y N

____