Renee Hilliard, M.D. Obstetrics and Gynecology

Annual Health History Update

Marital Status	Name	Age	Date
Current medications:	Marital Status	Best Phone # to reach you	
Current medications:	Why are you here today?		
Current medications:	Do you have any new medical concerns today	PY N	
Menstrual Cycle History: 1st day of your last period			
Menstrual Cycle History: 1st day of your last period	Medication allergies: Y N	Ar	re you allergic to latex? Y
1st day of your last period	Name of your primary / family physician		
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	Menstrual Cycle History:		
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	1st day of your last period	Was it normal?	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	Have you had a hysterectomy?	Y N Are your periods regular?	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 have: Excessive bleeding	Y N Mood Swings	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	Pain / Cramps	Y N Bleeding between periods	Y N
Depo-Provera Patch Abstinence Pills (fill in name) Other Are you happy with this method? Y N	Are you sexually Active? Y N	Do you have pain with intercourse?	Y N
Are you happy with this method? Y N	What are you doing to prevent pregnancy? N	one Condoms Tubal Ligation IUD	Vasectomy Ring
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	Depo-Provera Patch Abstinence	Pills (fill in name)	_ Other
Have you ever had an abnormal pap smear? Y N If yes, when	Are you happy with this method? Y N	f no, would you like a different method? Y	N
	When was your last pap smear?	Were the results:	Normal or Abnormal
Do you smake? V. N. If was how much? Do you avaraise? V. N. Dascriba	Have you ever had an abnormal pap sme	ar? Y N If yes, when	-
Do you shioke. 1 If It yes, now much: Do you exercise: 1 If Describe	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 urinary problems? Y N Ex	plain	
Are you having any problems with vaginal discharge? Y N Explain	Are you having any problems with vaginal dis	charge? Y N Explain	
Have you had? Mammogram: Y N When Bone density scan: Y N When	Have you had? Mammogram: Y N When	Bone density scan: Y N When	n
Colonoscopy: Y N When Cholesterol checked: Y N When	Colonoscopy: Y N When	Cholesterol checked: Y N Wh	nen
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			