Karen H. Clark, M.D.

ANNUAL UPDATE

NAME: _____ DATE OF BIRTH: _____ AGE: _____

Reason for your visit today: _____

Additional issues you would like to discuss today, time permitting: _____

_____

Primary care physician: _____

PAST MEDICAL HISTORY

Surgery done in since your last visit: _____

Please check any of the following illnesses that you currently have:

☐Asthma	☐Breast disease	☐Cancer
☐Diabetes	☐Elevated cholesterol/lipids	☐Fibromyalgia
☐Gallbladder disease	☐Heart disease	☐High blood pressure
☐Kidney infections / stones	☐Migraine / severe headaches	☐Mitral valve prolapse
☐Thyroid problems		

Injuries since last visit: _____

Immunizations:

☐HPV Last tetanus shot: _____

UPDATED GYNECOLOGIC HISTORY

Last menstrual period: _____

Number of days between the ***first*** day of your period to the ***first*** day of your next period: _____

Any recent changes in periods? _____

Do you have bleeding between periods? ☐ No ☐ Yes

Number of pads or tampons used on heaviest day of flow: _____

Menstrual cramps: ☐ None ☐ Mild ☐ Moderate ☐Severe

Last Pap smear: _____

Have you ever been treated for an abnormal Pap smear? ☐ Yes ☐ No

Explain: _____

Last mammogram: _____

Have you ever had an abnormal mammogram? ☐ Yes ☐ No

Explain: _____

Have you ever had a bone density scan performed? ☐ Yes ☐ No ☐ Date _____ Results: _____

Have you ever had colon cancer screening (colonoscopy or sigmoidoscopy)?

☐ Yes ☐ No ☐ Date _____

Are you interested in screening for sexually transmitted infections? ☐ Yes ☐ No

☐Chlamydia/ gonorrhea	☐ HIV	☐ Syphilis
☐ Hepatitis B	☐ Hepatitis C	☐ Trichomoniasis

UPDATED FAMILY HISTORY

Please check any of the following illnesses that run in your family:

☐Breast cancer	☐Heart disease	☐Diabetes
☐Ovarian cancer	☐Stroke	☐Thyroid problems / goiter
☐Colon cancer	☐High blood pressure	☐Osteoporosis

UPDATED SOCIAL HISTORY

Tobacco use: ☐ No ☐ Former smoker ☐ Yes Packs per day _____

Recreational/ Street Drug use: ☐ Yes ☐ No ☐ Previous

Alcohol use (including wine and beer): ☐ None ☐ Yes Drinks per week _____

Seatbelt use: ☐ Yes ☐ No ☐ Sometimes

Are you currently sexually active? ☐ Yes ☐ No

Do you need birth control? ☐ Yes ☐ No

What do you currently use for birth control? _____

Marital status: ☐ Single ☐ Married ☐ Domestic partnership ☐ Separated since _____ ☐ Divorced since _____ ☐ Widowed since _____

Occupation: _____

Do you get regular exercise? ☐ No ☐ Yes Describe: _____

Have you ever been abused, threatened, or hurt by anyone? ☐ No ☐ Yes

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ALLERGIES TO MEDICATIONS

Please list any medication allergies.

1. _____ 3. _____
2. _____ 4. _____

MEDICATIONS / VITAMINS / HERBS

Please list any medications, vitamins, or herbal supplements that you are currently using, including dose.

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Others: _____

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

(GENERAL)	☐Significant weight change	☐Fever	☐Sweats
(HEENT)	☐Use glasses/contacts ☐Other visual problems	☐Sinus problems	☐Ringing in ears
(RESP)	☐Chronic cough	☐Wheezing	☐Coughing up blood
(CV)	☐Chest pain	☐Shortness of breath	
(GI)	☐Nausea/vomiting	☐Blood in bowel movements	☐Frequent diarrhea
(BREAST)	☐Breast pain	☐Nipple discharge	☐Lumps
(GU)	☐Pain with urination ☐Involuntary loss of urine	☐Urinary frequency	☐ Blood in urine
(CNS)	☐Dizziness	☐Frequent headaches	
(SKIN)	☐Rashes	☐Non-healing sores	☐Changes in moles
(PSYCH)	☐Depression ☐Memory problems	☐Anxiety	☐Insomnia
(ENDO)	☐Temperature intolerance	☐Abnormal thirst	
(IMMUNO)	☐Allergies to pollens, grasses, or pets		☐Allergies to foods