

**URMC MIDWIFERY GROUP
ANNUAL EXAM HEALTH UPDATE**

Date: ____/____/_____
Time: _____

Welcome Back! Please fill in this side of the page.

Name: _____ DOB: ____/____/____

Address: _____

Phone number(s): (H) _____ (W) _____ (Cell) _____

Current occupation: _____

Describe changes in your living arrangements, significant other or family situation: _____

PCP: _____ Number of pregnancies: _____ Number of children: _____

CONCERNS YOU WOULD LIKE TO DISCUSS TODAY: _____

Do you want to be tested today for: HIV/AIDS? Yes No Sexually transmitted diseases? Yes No

List All Current Medications/ Vitamins/ Supplements:	
_____	_____
_____	_____
_____	_____
LIST ALL DRUG ALLERGIES _____	ALLERGIC TO LATEX? <input type="checkbox"/> Yes <input type="checkbox"/> No

Date of last menstrual period: ____/____/____ How often do you have a menstrual period? _____

List any menstrual problems? _____

Are you having sexual relations? Yes No New Partner? Yes No Male? Female? Both?

Current Birth Control Method: Pills IUD Condoms Patch Ring Sterilization Vasectomy

Do you have any pain? Yes No If so, where? _____

New medical problems since your last visit: _____ _____ _____ _____	Any surgery or medical procedures since your last visit: _____ _____ _____ _____
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Were any of your blood relatives diagnosed with a new major illness this year? Yes No

Describe: _____

Do you smoke: cigarettes? Yes No
marijuana? Yes No

How do you get exercise: _____

Do you follow a special diet? Yes No

Do you use drugs? Yes No

Type: _____

Do you drink alcohol? Yes No

Do you wear seat belts? Yes No

Frequency: _____ Date last dental exam? _____

Please Tell Us When You Had Your Last:

Pap smear: _____

Have You Been Tested For:

Cholesterol: No Yes, Year: _____

Mammogram: _____

Diabetes: No Yes, Year: _____

Colonoscopy: _____

Thyroid: No Yes, Year: _____

Flu shot _____

Have you completed the Hepatitis B vaccine? Yes No

Tetanus shot _____

Have you completed the HPV vaccine? Yes No