Riverview MEDICAL GROUP

PATIENT CLINICAL UPDATE

Date: _____

Name: _____DOB:_____ Allergies:_____

Please describe the reason for your visit today: _____

MENSTRUAL HISTORY

Age at onset: ____Last menstrual cycle _____
Do you have a period regularly every month? Yes No
Do you have bleeding between your periods? Yes No
Length of Cycle (from start to start): _____
Duration of bleeding: _____Days
Flow: Light Moderate Heavy
Pain/Cramps: Mild Moderate Severe

GYNECOLOGIC HISTORY

Method of Birth Control:_____
Prior Infections:
☐ Herpes ☐ Other _____
☐ PID
Have you had: ☐Abnormal Periods ☐Pelvic Pain
☐Ovarian Cysts ☐Endometriosis
☐Incontinence ☐Leakage of Urine
☐Pain during intercourse ☐Abnormal Pap Smear

Please indicate if you have had any medical changes during the past year (list condition and date of diagnosis).

PERSONAL HISTORY of Heart Disease, Blood Pressure, Stroke, Bleeding Disorders, Lung, Diabetes, Thyroid, Osteoarthritis, Depression/Anxiety, or Cancer_____

_____

Please indicate if a member of your family has had any medical changes during the past year (list condition and relationship to you and their age)

FAMILY HISTORY of Heart Disease, Blood Pressure, Stroke, Bleeding Disorders, Lung, Diabetes, Thyroid, Osteoarthritis, Depression/Anxiety, or Cancer_____

_____

SOCIAL HISTORY:
Cigarettes: ☐ Never ☐ Currently Age Started _____ Quit Date: _____
Alcohol: ☐ Never ☐ Occasionally ☐ Daily
Number of drinks per week _____ per day_____
Street Drugs: ☐Never ☐Marijuana ☐Cocaine ☐IV Drugs Other _____
Abuse: ☐Never ☐Currently ☐Past

MEDICATIONS: Please list any medications that you are taking.

PREGNANCY HISTORY DURING THE LAST YEAR (include miscarriages)

Year	Sex	Infant Weight	Type of Delivery	Hours of Labor	Complications	Gestational Age at Delivery (#of weeks)

SURGICAL HISTORY: Please list any surgeries within the past year.

HEALTH MAINTENANCE: Please list the date of your most recent exam. Mammogram_____

Bone Density_____Pap Smear_____Colonoscopy_____Vaccines_____