

Associated Women's Healthcare, LLP
ANNUAL HEALTH UPDATE

Name _____ Date _____

To assist us in keeping your medical history up-to-date, would you please answer the following questions?:

1. Has there been any change in your periods? Yes () No ()
If yes, please describe: _____
2. Are you using any birth control? Yes () No ()
If yes, what type? _____
3. Have you had any illnesses? Yes () No ()
If yes, please describe: _____
4. Have you had any surgeries since your last exam? Yes () No ()
If yes, please describe: _____
5. Have you seen any of your other doctors? Yes () No ()
If yes, who have you seen? _____
6. What medications are you taking? _____

7. Cigarettes Yes () No () _____ per day Alcohol Yes () No () Drug Use Yes () No ()
8. If you are over the age of 39, when did you last have the following tests?:
Mammogram: _____ Cholesterol test: _____ Stool test: _____
9. Please indicate the first day of your last menstrual period: _____
10. If there are any significant changes in your family history, please list: _____

PLEASE LIST YOUR CURRENT NAME, ADDRESS AND TELEPHONE NUMBERS

NAME: _____ PHONE NUMBERS: _____
ADDRESS: _____ HOME: _____
CITY, STATE, ZIP: _____ WORK: _____
E-MAIL ADDRESS: _____

Due to the enactment of the Clean Claims Act, we must have disclosure of any other health benefit plans. Please note below if you have more than one insurance plan.

I only have coverage under one insurance plan. _____

I have coverage under more than one insurance plan (if yes, please list name of insurance company). _____

Date: _____ Signed: _____