Gynecologic Yearly Update Form

*****This form must be COMPLETED and SUBMITTED to our office PRIOR to your appointment. If you are unable to do this, please phone our office at 309-692-6838 for special assistance.**

Name: _____ Date: _____ Date of Birth: _____

Primary Care Physician: _____ Pharmacy: _____ Address: _____

Please list any **NEW OPERATIONS**, **HOSPITALIZATIONS, or DIAGNOSES** that have occurred since your last visit:

_____

_____

Please list **ALL** current **MEDICATIONS** and **SUPPLEMENTS** or attach medication list:

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Please list **ALL** medication **ALLERGIES**: _____

What is your current **HEIGHT**? _____ What is your current **WEIGHT**? _____

What is the date of your **last menstrual period OR** at what age did you go through **menopause**? _____

Do you use **contraception**? If so, what type? _____

Have you had a **hysterectomy?** If so, when? _____

Have your **ovaries** been removed? If so, when? _____