ASSOCIATED GYNECOLOGY **ANNUAL UPDATE** **Date:_____**

Name:_____ Age_____

Primary Care/Family Doctor:_____ Insurance_____

Insurance Required Lab: __Labcorp __Quest __LabOne __ RENOWN Other _____

Required Radiology: (from insurance book)_____

ALLERGIES to medications:_____ Allergy to Latex?_____

MEDICATIONS: Include PRESCRIPTION, Nonprescription, herbal and vitamins:

_____ _____

_____ _____

_____ _____

LAST MENSTRUAL PERIOD: _____ Type of birth control?_____

Reason for today's visit:_____

PAST HISTORY UPDATE: Any new illnesses, hospitalizations, or surgery since last visit?_____

_____

FAMILY HISTORY UPDATE: Any new family history?_____

HABITS: ___TOBACCO _____Reg. Exercise _____ Take calcium ___Wear seatbelts

DATE OF: Last mammogram _____ Last colonoscopy?_____

SYSTEM REVIEW: Please circle all that apply

GYN	None	Irreg. bleeding Heavy periods Cramping Discharge Itching Burning Bumps Hot flushes Night sweats Vaginal dryness
Urinary	None	Incontinence Frequency Urgency Blood in urine Pain w/urination Falling out feeling
Breast	None	Pain Discharge Lump
GI	None	Nausea/vomiting Abd. Pain/cramping Diarrhea Constipation Bloody stools
Other	None	Unexplained weight gain Weight loss Fatigue Headaches
Other problems:		

MEDICARE PATIENTS: MAY GET ANNUAL COVERAGE IF YOU HAVE THE FOLLOWING HIGH RISK FACTORS (V15.89): Please check those that apply

___Age of 1st intercourse before age 16 ___5 or more sexual partners ___History of STD: HPV etc

___Fewer than 3 paps in past 7 years ___Exposure to DES

FOR INSURANCE BILLING: I, the undersigned, assign directly to Associated Gynecology, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance. I hereby authorize release of all information necessary to secure the payment of benefits.

_____ _____

Signature of Responsible Party Date