

DATE _____

Flower Mound Women's Health

Returning Annual Exam Update

In our effort to provide you the best care, we would like to update any new information. If you would please update the form below we would be most appreciative.

Name _____ DOB _____

• First day of last menstrual period _____

• Are your cycles regular? _____

• Date of last Mammogram _____

• Date of last Cholesterol Check _____

• Is there a Family History of Heart Disease or High Cholesterol? _____

• Use of contraceptive _____

• When was your last tetanus shot? _____

(CDC recommends you receive one at least every 10 years)

Drug

Allergies: _____

Current

Medications: _____

Any changes in medical history or

surgeries? _____

Patient Name: _____ Date of Birth: _____ Date: _____

Please check all that currently apply:

1. General Symptoms

- Weak, tired all the time
- Fevers
- Weight loss, unintentional
- Weight gain
- Lack of appetite
- Other _____
- None

2. Eyes

- Vision changes
- Other _____
- None

3. Ears, Nose, Throat

- Sinus trouble (sinusitis)
- Headache
- Tinnitus (ears ringing)
- Other _____
- None

4. Cardiovascular (Heart)

- Chest pains
- Shortness of breath
- Swelling or the feet
- Heart pounding or irregular heartbeat
- Difficulty breathing when sleeping
- Other _____
- None

5. Pulmonary (Lungs)

- Cough
- Wheezing
- Blood in sputum (spit)
- Other _____
- None

6. Gastrointestinal

- Diarrhea
- Constipation
- Rectal bleeding
- Stomach pains
- Gas/Bloating
- Leakage of stool
- Nausea or vomiting
- Other _____
- None

7. Urinary

- Blood in urine
- Burning with urination
- Frequent urination
- Urgency with urination
- Leakage of urine
- Incomplete emptying after urination
- Kidney Stones
- Other _____
- None

8. Musculoskeletal

- Muscle weakness
- Joint pains (arthritis)
- Back pain
- Other _____
- None

9. Skin and Breasts

- Rash
- Breast lump
- Breast pain
- Discharge from the nipple
- Other _____
- None

10. Neurologic

- Fainting
- Seizures
- Numbness
- Trouble walking or with balance
- Other _____
- None

11. Psychiatric

- Depression
- Anxiety
- Other _____
- None

12. Endocrine

- Hot flashes
- Diabetes mellitus
- Thyroid gland problems
- Other _____
- None

13. Hematologic & Lymphatic

- Bruising easily
- Bleeding
- Enlarged lymph glands
- Other _____
- None

14. Gynecologic

- Problem becoming pregnant
- Abnormal vaginal bleeding
- Abnormal vaginal discharge
- Pelvic pain
- Pain with sexual intercourse
- Pelvic infections
- Mass protrusion from vagina/fullness
- Other _____
- None

15. Do you smoke? Yes No

16. Do you regularly exercise? Yes No

17. Do you feel that you practice healthy eating habits? Yes No

I have reviewed the above findings.

Physician Signature: _____ Date: _____

PATIENT CONSENT FORM

I understand that as a part of my healthcare, Flower Mound Women’s Health, P.A. (“the PRACTICE”) originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information is utilized to plan my care and treatment, to bill for services provided to me, to communicate with other healthcare providers and routine healthcare operations such as assessing quality and reviewing competence of healthcare professionals.

The PRACTICE’S *Notice of Privacy Practices* provides specific information and complete description of how my personal health information may be used and disclosed. I have been provided a copy of or access to the *Notice of Privacy Practices* and understand that I have the right to review the notice prior to signing this consent. I understand that I have the right to restrict the use and/or disclosure of my personal health information for treatment, payment or healthcare operations and that the PRACTICE is required to agree to the restrictions requested. I may revoke this consent at any time in writing except to the extent that the PRACTICE has already taken action in reliance on my prior consent. The consent is valid until revoked by me in writing.

- I request the following restrictions on the use and/or disclosure of my personal health information.

I further understand that any and all records, whether written, oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.

I have been provided and have reviewed the PRACTICE’S *Notice of Privacy Practices* dated 10-01-02.

Signature of Patient or Legal Representative

Date

Print Name of Patient or Legal Representative

I hereby give my authorization to disclose my protected health information, only in the specific manner, for the names reason, and to the specific individual(s) below:

Specific description of information to be released:

Person(s) you allow to request and receive the information stated above:

I understand this authorization provides that:

I have the right to access my protected health information to be used or disclosed.

I may revoke this authorization at any time by contacting your Privacy Officer in writing, at the address above.

Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by HIPAA privacy rules.

This practice will not condition treatment on my providing authorization for the requested use of disclosure.

I will receive a copy of this completed and signed authorization form.

Signature: _____ **Date:** _____

Relationship to patient (if signed by a representative of patient) _____