



Arbor Obstetrics and Gynecology Annual Health and Wellness Update

We are pleased to see you for annual exam. Having an annual exam is an excellent way of making sure you are up to date on all necessary tests and exams. It is also a good time to review your lifestyle and health habits to make sure you are doing everything possible to ensure that you will remain free of injury and disease. The following questionnaire is detailed, but it has been carefully written to help us identify those things in your life that are most likely to impact your life. We appreciate you taking the time to fill it out accurately and completely.

Name: _____ Today's Date: _____
Date of last menstrual period: _____ Date of last annual exam _____

Who is your primary care doctor (please give name and office number if known)?

Have you had any changes in your health or medical history since your last yearly exam with us?
(For example: newly diagnosed with diabetes, high blood pressure or other)

What medications do you take? Please list names and dosages of all current medications, including birth control (even if they are not different from last year).

Have you had any new surgeries, procedures or been hospitalized for any reason since your last annual exam?

Do you have regular menstrual cycles? _____

Are you having any problems with your menstrual cycles? _____

Are you sexually active? _____

(If applicable please answer the following questions)

Are you with a new partner since last year? _____

If yes, how many partners have you had in the last year? _____

If you are not in a long term monogamous relationship do you always use a condom and practice safe sex? _____

Would you like to be tested for sexually transmitted diseases? _____

(Continued on the next/reverse page)



Have there been any social changes in your life since your last yearly exam? (Such as marriage, divorce, new child, loss of parent or loved one, new job, etc.)

Are you generally happy with your work or school and social/ family situations?

Do you use tobacco? _____ Do you use any recreational drugs? _____

If you drink alcohol, how many drinks do you generally drink per week? _____

Do you regularly have any of the following symptoms? (Please circle)

Recurrent fevers/ persistently swollen glands/ skin rashes/ sores on the skin/ chronic itching/
severe headaches/ episodes of fainting/ seizures/ numbness or muscle weakness/ cough/
shortness of breath/ wheezing/ chest pain/ swelling of the legs/ hot or cold intolerance/
significant weight change/ abnormal hair growth/ excessive thirst/ abnormally frequent
urination/ blood in the urine/ abnormal bruising or bleeding/ severe mood swings/ depression/
anxiety/ joint pain or swelling/ difficulty moving any joints/ pain with intercourse/ pain with
menstrual cycles/ vaginal discharge or odor/ sores in the genital area/ leaking of urine/ hot
flashes/ vaginal dryness

Has anyone in your family been diagnosed with new health problems since your last visit?

Do you do the following?

Self breast exam at least once a month? _____

Wear a seatbelt in the car at all times? _____

Engage in aerobic exercise at least 3 times per week? _____

Take a calcium supplement every day? _____

Take folic acid or multivitamin with folic acid in it every day? _____

Sunbathe or use a tanning bed? _____

Generally eat a healthy diet? _____

See a dentist or hygienist and an eye doctor at least annually? _____

Are you exposed to violence of any type (physical or emotional)? _____

Are there any issues or concerns which you would like to discuss that have not been addressed in the questionnaire?
