Franciscan PHYSICIAN NETWORK

WELLNESS HISTORY UPDATE QUESTIONNAIRE FOR RETURNING PATIENTS

The location of your appointment is:

☐ Franciscan Physician Network - Obstetrics & Gynecology - Lafayette
3920 St Francis Way, Lafayette IN 47905

☐ Franciscan Physician Network - Obstetrics & Gynecology - Crawfordsville
1630 Lafayette Road, Suite 400, Crawfordsville IN 47933

Please provide the following information regarding your health and your family's health since your last visit. Please bring this to your upcoming appointment.

Name:_____ Birthdate:_____

Date of upcoming appointment:_____ with Physician/Nurse Practitioner:_____

GYN UPDATE

If you have not had any vaginal bleeding since your last visit, please skip to Question #4.

1) What was the first day of your last menstrual period?_____

2) Have you had any troublesome change in your menstrual periods since your last visit here?.....YES NO

3) What is your current method of birth control? Circle all that apply:

No sexual intercourse	IUD
No method – pregnancy would be:	Diaphragm
Good Not good (circle one)	Condoms
Tubes tied	Rhythm – calendar method
Partner's vasectomy	Rhythm – temperature method
Contraceptive Implants	Rhythm – mucous method
Depo Provera shot	Withdrawal
Birth Control pills	Spermicide

MEDICAL UPDATE

Since your last visit here, have you:

4) seen any other physician?.....YES NO

If yes, please list:

Who	For what problem	When
_____	_____	_____
_____	_____	_____
_____	_____	_____

5) been hospitalized for illness and/or surgery?.....YES NO

If yes, please list:

When	For what problem
_____	_____
_____	_____

6) Have you had a blood transfusion prior to 1992?.....YES NO

Name:_____ Birthdate:_____

7) Please list current medications:

Name	Reason for taking
_____	_____
_____	_____
_____	_____

8) Any allergic or other bad reactions to medications since your last visit?.....YES NO

If yes, what medications?_____

what reaction?_____

9) When was your most recent cholesterol test done?_____

What was the result?_____ Where was it done?_____

SOCIAL HISTORY

Since your last visit here, have you:

10) had any new sexual partners?.....YES NO

11) had a change in marital status?.....YES NO

If yes, describe:_____

12) changed occupations?.....YES NO

If yes, describe:_____

13) Do you smoke?.....YES NO

If yes, how much?_____

14) On the average, how much alcohol do you drink? _____servings per _____

15) Do you check your breasts for lumps?.....YES NO

If yes, how often?_____

16) Since your last visit, have any close relatives developed high blood pressure, heart disease, stroke, high cholesterol, diabetes, breast cancer, ovarian cancer, colon cancer, osteoporosis, or any other familial health problems? If yes, pleased describe:_____

_____

_____

17) Any other information you think we should know?_____

_____

Name:_____ DOB: _____

REVIEW OF SYSTEMS: Have you recently been troubled with any of the following:

GENERAL HEALTH:	YES	NO	**GENITOURINARY:**	YES	NO
Unexplained weight loss			Pain with urination		
Unexplained weight gain			Blood in urine		
Fever			Frequent urination		
Fatigue			Urine loss with strong urge to void		
Hot flashes			Urine loss with cough/sneeze/laugh		
			Incomplete emptying of bladder		
EARS/NOSE/MOUTH/THROAT:			Pain with or after sex		
Unusual or frequent headaches			Bleeding with sex		
Hearing loss			Vaginal dryness with intercourse		
Ringing in ears			Low sex drive		
			Abnormal vaginal discharge		
EYES:			Vaginal itching and/or burning		
Visual changes			Foul vaginal odor		
BREAST:			**MUSCULOSKELETAL:**		
Mass/lump in breast(s)			Weak muscles		
Nipple discharge			Joint pain		
			Back pain		
CARDIOVASCULAR:					
Chest pains			**SKIN:**		
Palpitations			Changing or new moles		
RESPIRATORY:			**NEUROLOGIC:**		
Wheezing			Faintness		
Cough up blood			Numbness or tingling in legs or arms		
Persistent cough					
Difficulty breathing			**PSYCHIATRIC:**		
			Severe anxiety		
GASTROINTESTINAL:			Depressed feeling		
Diarrhea			Crying spells		
Blood in stools			Feel like committing suicide		
Constipation(infreq and/or hard stools)					
Stomach and/or pelvic pain			**ENDOCRINE:**		
Fecal incontinence			Excessive thirst		
Nausea			Heat intolerance		
Vomiting			Cold intolerance		
Abdominal enlargement			Excessive hair growth (ie face)		
Indigestion					
Loss of appetite			**LYMPHATIC/BLOOD:**		
			Excessive bleeding when cut		
			Easy bruising		
			Swollen lymph nodes or glands		