KAMM MCKENZIE OBGYN

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****ANNUAL UPDATE FORM****

Please fill out this form completely, noting any UPDATES from your MOST RECENT ANNUAL WELLNESS VISIT. This is a confidential record of your medical information.

Patient Name: ________________________________ **Preferred Name:** ____________________________

DOB: ________________ **Preferred Pronouns** (circle one): She/Her He/Him They/Their Other

MEDICATIONS/SUPPLEMENTS- Please list any changes in medications or supplements you are taking.

____

MEDICAL/SURGICAL HISTORY- Please list any new medical conditions, diagnoses, or surgeries.

____

PREVENTATIVE HEALTH SCREENINGS- Please list the date/ results of your most recent screenings.

- Pap Smear: _________________________
- Mammogram: ______________________
- Colonoscopy: ________________________
- Bone Density: _________________________
- Cholesterol: __________________________
- Diabetes Screening: ____________________

SEXUAL HEALTH / REPRODUCTIVE HISTORY- Please circle or fill in the blanks.

- **1st day** of your last menstrual period: _______________ Are you certain of this date? Yes No
  - Have you taken a home pregnancy test since your last period? Yes No Result: ___________
- Are you currently sexually active (circle one)? Yes No
  - If YES, is your Partner (circle all that apply): Male Female Other Gender Identity
- Are you using any method of pregnancy prevention? Yes No Method? ________________________
- Are you currently trying to conceive? Yes No

SOCIAL HISTORY - Please circle or fill in the blanks.

- Marital Status (circle one): Single Engaged Married Divorced Separated Widowed
- Occupation: __________________________________

- Do you Exercise (circle one)?: Yes No Type /Frequency: ___________________________________
- Alcohol Intake: Number of drinks per week: ____________ Type: _____________________
- Tobacco Use (circle one): Never Former Current - # Packs per day: ________ # of years: _______
- Marijuana Use (circle one): Never Sometimes Regularly
- Illicit Drugs (circle one): Never Former Current - Type/Frequency: ______________________

DOMESTIC VIOLENCE SCREENING:

- Have you ever been the victim of any form of Domestic Abuse (circle *all* that apply)?

  Sexual Abuse Physical Abuse Emotional Abuse Verbal Abuse No History of Abuse

  - If YES, list dates: _______________________ Are you safe now (circle one)? Yes No

DEPRESSION SCREENING: THE PATIENT HEALTH QUESTIONNAIRE-2

Over the past 2 weeks, how often have you been bothered by any of the following problems? (circle one)	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3

Patient Signature: ____ **Date:** _______________________

Legal Guardian (if minor): ____