

**GENESIS WOMENS CARE  
ANNUAL MEDICAL UPDATE**

**DATE:** \_\_\_\_\_

**NAME:** \_\_\_\_\_

Please help us update your records by providing us with the following information. Please fill in all blanks.

Your age: \_\_\_\_\_

What medical concerns did you have this year? \_\_\_\_\_  
\_\_\_\_\_

First day of your last normal period: \_\_\_\_\_

First day of the previous period: \_\_\_\_\_

Are your periods regular? \_\_\_\_\_ How many days in a cycle? \_\_\_\_\_

How heavy is the bleeding? \_\_\_\_\_ How many days of bleeding? \_\_\_\_\_

Are your periods painful? \_\_\_\_\_

Are you sexually active? \_\_\_\_\_ Do you have pain with intercourse? \_\_\_\_\_

What do you do to prevent pregnancy? \_\_\_\_\_

If birth control pills, what brand? \_\_\_\_\_

Are you satisfied with this method? \_\_\_\_\_

Name of your family physician: \_\_\_\_\_

Do you smoke? \_\_\_\_\_ How much? \_\_\_\_\_

Do you exercise? \_\_\_\_\_ What type? \_\_\_\_\_

Have you had any medical problems in the past year, i.e., surgery, accidents or medical problems? If so, explain: \_\_\_\_\_  
\_\_\_\_\_

Have you had any bloodwork, labs or x-rays in the past year? If so, please list: \_\_\_\_\_  
\_\_\_\_\_

Have you had a mammogram. If so, when and where performed. \_\_\_\_\_

Are you doing a self breast exam? \_\_\_\_\_ Every month? \_\_\_\_\_

Are you taking any medications? If so, please list: \_\_\_\_\_

Are you allergic to any medications? If so, please list: \_\_\_\_\_

Have there been any new family medical problems, i.e., cancer? \_\_\_\_\_

*Thank you for taking the time to provide this information.*

