

Western Carolina Women's Specialty Center

Patient Return Visit Information Update

Patient Name _____ DOB: _____ SS# _____

Date ____/____/200__ Reason for today's visit _____

Home PH (____) ____-____ Cell PH (____) ____-____ Work PH (____) ____-____

Current Address _____ City _____

State _____ ZIP _____

Insurance Carrier _____

Insurance ID# _____ Insured's DOB _____

Insured's SS# _____-_____-_____

Family physician or specialist that you see _____

Please List Your Current Medications: _____

Please check next to any of the following problems which you are having:

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Unexplained weight loss | <input type="checkbox"/> Muscle or joint pain | <input type="checkbox"/> Loss of bowel contents | <input type="checkbox"/> Hot flashes |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Skin or mole changes | <input type="checkbox"/> Low back pain | <input type="checkbox"/> Night sweats |
| <input type="checkbox"/> Vision changes | <input type="checkbox"/> Fainting, seizures | <input type="checkbox"/> Bleeding between cycles | <input type="checkbox"/> Trouble sleeping |
| <input type="checkbox"/> Ear, nose, throat problems | <input type="checkbox"/> Numbness, tingling | <input type="checkbox"/> Heavy bleeding | <input type="checkbox"/> Mood swings |
| <input type="checkbox"/> Chest pain with exertion | <input type="checkbox"/> Feeling depressed | <input type="checkbox"/> Painful periods | <input type="checkbox"/> Vaginal dryness |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Nausea or vomiting | <input type="checkbox"/> Pain with sex | <input type="checkbox"/> Decreased sex drive |
| <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Constipation | <input type="checkbox"/> Vaginal discharge | <input type="checkbox"/> Bleeding after
menopause |
| <input type="checkbox"/> Pain with urination | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Breast lump | |
| <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Black stools | <input type="checkbox"/> Nipple discharge | |
| <input type="checkbox"/> Loss of urine | <input type="checkbox"/> Bloody stools | <input type="checkbox"/> Breast pain | |

Screening Tests: Last Pap _____ Last Mammogram _____ Last Colonoscopy _____
Last Bone Density _____ Last Cholesterol _____ Last Ultrasound _____

Current method of birth control (if applicable) _____

List any new allergies _____

List any new surgeries _____

List any new medical problems _____

Date of last menstrual period (if applicable) _____

Please list any other issues you wish to discuss with your doctor _____

MD Reviewed _____