Pearl W. Yee, M.D. Inc.
Obstetrics • Gynecology • Medical Aesthetics • Menopause • Prevention of Hereditary Cancer
Minimally Invasive and Robotic Gynecological Surgery

ANNUAL UPDATE FORM

DATE: ______/ _______/_______ AGE: ______________________

NAME: ____ DATE OF BIRTH: ______/______/______

Address: ____

Home #: ______________________ Cell#: _____________________ Work #: ____________________

E-mail address:____

I. When was the first day of your last menstrual period or year of menopause? ________________________

II. Since your last visit, have you have changes to the following below?
No Yes: Please detail below
1. Allergies: ____

2. Medications (type and dosages): ____
____

3. Gyn Issues (infections, pregnancies, etc): ____
____

4. Medical Problems/Surgeries/Hospitalizations: ____
____

5. Family History: ____

6. Do you currently smoke, drink alcohol or use drugs? ☐ No ☐ Yes
(If yes, how much and how often?)

III. New Social History, Life Events, Interests: ____
____

IV. Is there anything you want to talk to your physician about?
____
____
____

RECENT PERSONAL HISTORY

Have you been recently hurt or threatened emotionally or physically? ☐ No ☐ Yes
Has anyone, including your partner, recently forced you to have sex? ☐ No ☐ Yes
Are you afraid of your partner? ☐ No ☐ Yes

Name:____ DOB:______________________________

Review of Systems

Please check if you have any of the following symptoms:

1. Constitutional		**Notes**	**7. Genitourinary (cont.)**		**Notes**
Fever	☐		Abnormal bleeding	☐	
Chills	☐		Vaginal discharge/odor	☐	
Fatigue	☐		Vaginal itching/burning	☐	
Weight loss	☐		Pelvic pain	☐	
Weight gain	☐		Menstrual cramps	☐	
2. Eyes			Painful intercourse	☐	
Change in vision	☐		Genital lump	☐	
Double vision	☐		Fertility concerns	☐	
3. ENT/Mouth			Menopausal concerns	☐	
Ear aches	☐		**8. Musculoskeletal**		
Ringing in the ears	☐		Muscle weakness	☐	
Sinus problems	☐		Joint stiffness	☐	
Sore throat	☐		Joint pain	☐	
Mouth sores	☐		Joint swelling	☐	
Dry Mouth	☐		**9. Skin/Breast**		
4. Cardiovascular			Breast pain	☐	
Chest pain	☐		Nipple discharge	☐	
Difficulty breathing on exertion	☐		Breast lumps	☐	
Swelling of legs	☐		Rash	☐	
Palpitations	☐		Ulcers	☐	
Heart Murmurs	☐		**10. Psychiatric**		
5. Respiratory			Depression	☐	
Wheezing	☐		Mood swings	☐	
Spitting up blood	☐		Anxiety	☐	
Shortness of breath	☐		Suicidal thoughts	☐	
Cough	☐		Homicidal thoughts	☐	
6. Gastrointestinal			**11. Endocrine**		
Diarrhea	☐		Abnormal thirst	☐	
Constipation	☐		Hot flashes	☐	
Nausea/vomiting	☐		Tremors	☐	
Bloody stool	☐		Cold/heat intolerance	☐	
Abdominal pain	☐		**12. Hematologic**		
Indigestion	☐		Frequent bruising	☐	
Bloating	☐		Cuts do not stop bleeding	☐	
Liver problem/Hepatitis	☐		Enlarged lymph nodes	☐	
7. Genitourinary			**13. Had blood transfusion?**	☐	
Blood in urine	☐		**14. Any antibiotics needed before dental work?**	☐	
Pain with urination	☐		**15. How tall are you?**	☐	
Urgency	☐				
Urinary Frequency	☐				
Urinary Incontinence	☐				

Please bring the above to the attention of your Primary Care Physician if not addressed today.