Progressive
WOMEN'S CARE

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HISTORY UPDATE

NAME: _____ **DATE: _____**

Thank you for taking the time to answer these questions.
Most insurance companies require this information to be updated at **EVERY** visit.

Please check any symptoms which you are currently experiencing.

General		**Gastrointestinal**		**Head/Ears/Nose/Throat**	
	Fatigue		Nausea/vomiting		Headache
	Weight loss		Diarrhea		Sore throat
	Weight gain		Constipation		Decreased hearing
			Abdominal pain		Congestion
Skin/Hair		**Breast**		**Neurologic**	
	Rash		Breast lumps		Seizures
	Skin lesions		Breast Tenderness		Tingling
			Nipple Discharge		Numbness
Cardiovascular		**Musculoskeletal**		**Respiratory**	
	Chest pain		Joint pain		Cough
	Irregular heartbeat		Joint Swelling		Wheezing
					Shortness of breath
Endocrine					
	Hair loss				
	Temperature intolerance				
	Abnormal hair growth				

When was your last menstrual period? _____

Have you had any serious illnesses, operations, or hospitalizations since your last visit?

_____

Have you discovered any additional information about your family history that we should know?

_____

Have you changed any habits (smoking, drinking, etc.) or occupation since your last visit?

_____

Please list all current medications and doses including vitamins and herbals

_____ _____ _____ _____

_____ _____ _____ _____

Please list any current allergies: _____

Please briefly describe the reason for your visit today: _____

_____