

**PAUL DUBRICK, M.D.---BRYAN KRUSKOL, D.O.----MEERA ATKINS, M.D.**  
**SUBSEQUENT VISIT UPDATE**

**To our patients:** Please take a few moments to update on any changes that may have occurred regarding either your health or that of any family member since your last visit. Such information is very helpful in appraising your current medical status.

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

DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

AGE: \_\_\_\_\_ Present Marital Status  M S D W

1. Have you had any tests (x-rays, lab work, etc.) since your last visit?    YES        NO  
If yes, please specify \_\_\_\_\_

2. Have you been hospitalized or had surgery since your last visit?    YES        NO  
If yes, please specify \_\_\_\_\_

3. Have there been any illnesses or deaths in your family since your last visit?    YES        NO  
Please specify illness and/ or causes of death, and individual's relationship to you:  
\_\_\_\_\_

4. Have you started taking any new medications or changed medications, since your last visit (prescription and non-prescription)?    YES    NO  
If yes, please indicate the product(s) and the reason(s) you started or changed: \_\_\_\_\_  
\_\_\_\_\_

5. Have there been any changes to your diet since your last visit?    YES    NO  
If yes, please specify: \_\_\_\_\_  
\_\_\_\_\_

6. Below, please indicate any changes in your medical status since your last visit:  
a. Weight gain or loss  
b. Changes in appetite

- c. Bladder/urinary problems
- d. Sexually Transmitted Disease
- e. Vaginal infections/discharge
- f. Martial/sexual problems
- g. Abdominal pain
- h. Breast discharge
- i. Menstrual changes
- j. Bowel Problems
- k. Other:

7. Indicate your consumption of the following:  
Alcohol---glasses per week: \_\_\_\_\_  
Cigarettes—packs per day: \_\_\_\_\_

8. **A Hit, a slap, a punch. THREATENED? Yelled or cursed at? No matter how you say it, it's all abuse. Talking about abuse isn't easy. You may not be ready today. When you are, we're here to listen. Sometimes talking can help.**

9. Date of first day of last period: \_\_\_\_/\_\_\_\_/\_\_\_\_

10. Usual time between periods: \_\_\_\_\_

11. Usual number of days for each period: \_\_\_\_\_

12. Do you bleed or spot between periods?  
YES    NO

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Are you currently using birth control? YES NO

If yes, please specify: \_\_\_\_\_

If yes, has your use of birth control changed?

YES NO

Please specify: \_\_\_\_\_

If you are NOT currently using birth control, and are sexually active, please indicate for how long: \_\_\_\_\_

**13. If there has been any change in your sexual activity or sexual partner since your last visit, or if you may have been exposed to a sexually transmitted disease, let your doctor know.**

14. Any drug/medication allergies? YES NO

If yes, please list: \_\_\_\_\_

15. Have you had a mammogram? \_\_\_\_\_ Date of most recent one? \_\_\_\_\_ Do you need to be instructed on self breast exams? YES NO

16. Have you had a tetanus booster in the last 10 years? \_\_\_\_\_ Would you like one today? \_\_\_\_\_

17. Any changes in your cardio-vascular status?

YES NO \_\_\_\_\_

18. Do you need your cholesterol checked?

YES NO

19. Reason for this visit? \_\_\_\_\_

\_\_\_\_\_