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	Lab
	Ref

Annual Update Form

Name: _____ Date of birth: _____ Age: _____

Primary care doctor: _____

Reason for your visit _____

Preferred pharmacy: name _____ location _____

Last menstrual period _____

Are you sexually active with: ☐1 partner ☐ multiple partners ☐men ☐ women ☐ men and women ☐ none

What do you use for birth control? ☐partner has vasectomy ☐birth control pills ☐condoms ☐IUD ☐tubal ☐NuvaRing ☐ implant ☐ diaphragm ☐ Depo-Provera ☐ Nothing

Would you like to be screened for sexually transmitted infections? ☐ Yes ☐ No

Have you been physically hurt by your partner or ex-partner? ☐ Yes ☐ No

Have you been emotionally abused by your partner or ex-partner? ☐ Yes ☐ No

OVER THE PAST TWO WEEKS, how often have you been bothered by any of the following problems?

	Not at all	Several days	Over half the days	Nearly every day
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

Please indicate your level of the following symptoms:

Symptom	None	Mild	Moderate	Severe
Hot flashes				
Heat intolerance				
Sleep problems				
Depressed mood				
Irritability				
Anxiety				
Fatigue				
Sexual problems/decreased libido				
Bladder problems				
Vaginal dryness/pain with intercourse				
Joint and muscular symptoms				
Difficulties with memory				
Problems with thinking, concentrating, or reasoning				
Difficulty learning new things				
Word loss				
Increased in frequency or intensity of headaches				
Hair loss, change in hair texture				
Cold intolerance				
Weight gain, difficulty losing weight				
Dry or wrinkled skin				

04/16/2023