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Obstetrics and Gynecology

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## HEALTH UPDATE - REVIEW OF SYSTEMS

**Patient Name** \_\_\_\_\_ **DOB** \_\_\_\_\_ **Date** \_\_\_\_\_

**New Address**

**New Phone Number**

**New Insurance Information**

\_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_ hm / wk / cell \_\_\_\_\_

\_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_ hm / wk / cell \_\_\_\_\_  
City State Zip Code

Referring Physician (If any) \_\_\_\_\_

Chief Complaint \_\_\_\_\_

How long have you had the symptoms? \_\_\_\_\_

What have you tried to relieve your symptoms? \_\_\_\_\_

Are your symptoms mild, moderate, or severe? \_\_\_\_\_

What makes your symptoms better or worse? \_\_\_\_\_

Circle any associated symptoms:

Fever	Weight Gain	Headaches	Palpitations	Shortness of Breath
Nausea	Vomiting	Constipation	Diarrhea	Abdominal Pain
Pelvic Pain	Hot Flashes	Anxiety	Breast Pain	Abnormal Periods
Incontinence	Skin Lesions	Breast Lump	Swollen Glands	Painful Intercourse
Urinary Burning	Urinary Frequency	Other _____		

Last menstrual period or year of menopause \_\_\_\_\_

Birth Control method \_\_\_\_\_

Could you be pregnant? \_\_\_\_\_ Are you planning pregnancy? \_\_\_\_\_

Allergies \_\_\_\_\_

Medications \_\_\_\_\_

New family history since last visit? \_\_\_\_\_

New medical history since last visit? \_\_\_\_\_

Surgeries since last visit? \_\_\_\_\_

Do you smoke? \_\_\_\_\_ Do you drink? \_\_\_\_\_ Do you use recreational drugs? \_\_\_\_\_

Stresses since last visit (ex. Divorce, Death of a spouse, Move) \_\_\_\_\_

**PATIENT SIGNATURE** \_\_\_\_\_