ALABAMA DEPARTMENT OF PUBLIC HEALTH
PATIENT SELF HISTORY UPDATE FORM

LABEL

For office use only: ☐ Cancer Detection ☐ Family Planning
☐ Well Woman ☐ WISEWOMAN ☐ Deferral ☐ Problem visit

Name:_____ Date:_____
Reason for your visit: _____
Last Menstrual Period:_____ Current Birth Control Method:_____
Since your last visit, have you developed any new drug allergies or intolerance? ☐ Yes ☐ No
If yes, please give details: _____

Since your last visit to our clinic, have you started any new medications, including over-the-counter medications, herbal medications, vitamins or minerals? ☐ Yes ☐ No If yes, please list the new medications

_____
_____

Since your last visit to our clinic, have you been to the emergency room, been admitted to the hospital, or had any new surgeries? ☐ Yes ☐ No
If yes, please write where and when: _____
If yes, please check any that apply:

☐Mammogram (breast x-ray)	☐Pap smear (for women)	☐Colonoscopy
☐Blood work	☐X-rays	☐ECG / EKG (heart)
☐Vision	☐DEXA (checks for bone loss, or osteoporosis)	☐other _____
☐MRI	☐CT ("CAT" scan)	

List where and when you had the tests done._____

Have you ever had any sexually transmitted diseases? ☐ Yes ☐ No If yes, check all that apply
☐ Trichomonas ☐Chlamydia ☐Gonorrhea ☐Vaginal infections ☐ Hepatitis C ☐Genital warts ☐Herpes – genital ☐Syphilis
☐ HPV ☐ HIV

Are you up to date with your Immunizations? ☐ Yes ☐ No
If no NEW symptoms, history, or medications (STOP HERE.) Otherwise, please complete below.
NEW Symptoms: Check all that apply.

❑Weight loss or gain	❑Non-healing sores	❑Urinary urgency	❑Depression
❑Fatigue	❑Lumps / Swollen glands	❑Pain/burning with urination	❑Anxiety
❑ Fever, chills, or sweats	❑Trouble swallowing	❑Calf pain with walking	❑Abdominal or pelvic pain
❑Heartburn	❑ Breast Lumps, Nipple Discharge, Pain	❑Dizziness	❑Urinary leakage
❑Nausea	❑Shortness of breath	❑Fainting	❑Vaginal dryness
❑Skin rash	❑Chest pain or discomfort	❑Hoarseness	❑Vaginal bleeding
❑Vision / Hearing problems	❑Constipation/ Diarrhea/ Blood in stool	❑Headaches – migraine or tension	❑Hot flashes
❑Blurry or double vision	❑ Rectal bleeding	❑Heat or cold intolerance	❑Vaginal discharge
❑Numbness/tingling/weakness of extremities	❑Thirst	❑Vaginal/Vulvar itching or irritation	

_____
Patient Signature and/or Signature of Interpreter/ Translator # Date

Nurse's Comments:
_____
_____
_____
_____
Reviewed By: Nurse's Signature Date

Physician or Nurse Practitioner Comments:
_____
_____
_____
_____
Physician or Nurse Practitioner Signature Date