



Obstetrics • Gynecology • High Risk Pregnancies • Board Certified

*Dr. Kimberly Turner*

Excellence in Care for Women Through Every Stage of Life.

***History and Physical Update***

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

Please state briefly the nature of today's visit:

\_\_\_\_\_  
\_\_\_\_\_

Please review and update your medical history

Since your last visit have any of the following things occurred?

- Changes in your medical health? Yes / No
- Surgery? Yes / No
- Birth of a child/pregnancy? Yes / No
- Change in your daily medication? Yes / No
- Change in marital status? Yes / No
- If yes, are you newly married/remarried/separated/divorced/widowed
- Other \_\_\_\_\_

Are you currently experiencing any of the following symptoms? (circle all that apply)

Weight change  
 Blackouts  
 Rash  
 Dizziness  
 Fever  
 Wheezing  
 Fatigue  
 Diarrhea  
 Constipation  
 Cough  
 Headaches  
 Seizures  
 Bruising  
 Paralysis  
 Shortness of Breath

Muscle Ache  
 Abdominal Pain  
 Tingling  
 Visual Changes  
 Cramps  
 Frequent Urination  
 Numbness  
 Heavy Menstrual Periods  
 Swelling  
 Nausea  
 Nosebleeds  
 Vomiting  
 Deafness  
 Backache  
 Painful Urination

Depression  
 Joint Pain/Stiffness  
 Congestion  
 Hot Flashes  
 Fainting  
 Increased Sweating  
 Chest Pain  
 Rectal Bleeding  
 Memory Loss  
 Increased Hunger  
 Increased Thirst  
 Blood in Urine  
 Hoarseness  
 Breast Pain  
 Heat/Cold Intolerance

I have reviewed the above information and it is accurate to the best of my knowledge.

Patient's Signature: \_\_\_\_\_

Doctor's Signature: \_\_\_\_\_