Interval Gynecology History

Patient's Name: _____

ID No.: _____

In order to provide you with more effective medical care, your doctor needs certain basic information about your recent medical history. The few minutes you spend on these questions will be an important contribution to your overall health care.

	YES	NO
1. The reason for your visit today is: _____		
2. Since your last visit here, have you acquired any allergies to medication?	❑	❑
If Yes, which medication(s)? _____		
3. Are you currently taking any medication?	❑	❑
If Yes, list the medication(s) you are currently taking: _____		
4. Are you currently taking any non-prescribed or street drugs?	❑	❑
If Yes, what type and amount do you consume on a daily basis? type_____ , _____/day		
5. Do you currently drink alcohol?	❑	❑
If Yes, what type and amount do you consume in a typical day? type_____ , _____/day		
6. Do you currently smoke?	❑	❑
If Yes, how much do you smoke on a daily basis? _____/day		
7. How much caffeine do you consume on a daily basis? ❑ none ❑ 1-2 cups ❑ 3-4 cups ❑ 5 or more cups		
If you have not begun to menstruate, are past menopause, or have had a hysterectomy, skip to question 19.		
8. Please indicate your present method of birth control. ❑ None, or _____		
9. Do you think you might be pregnant?	❑	❑
10. Your last menstrual period began on _____/_____/_____		
11. Have you noticed anything different about your periods?	❑	❑
12. How long is it between the start of one period and the start of the next? _____days or _____months		
13. How long do your periods last? _____days		
14. Write in the number and size of tampons and/or pads that you use on your "heaviest" day.		
____ _____tampons and/or ____ _____pads		
15. Do you skip periods?	❑	❑
16. During or between periods, do you have pains/pressure in your lower back, abdomen or pelvis?	❑	❑
17. Have you had any spotting and/or bleeding between periods?	❑	❑
18. Write in any other changes related to your periods _____		
19. Have you noticed any unusual vaginal odor, discharge or itching?	❑	❑
If Yes, how long has this been happening? _____		
how often does it happen? _____		
have you tried to relieve it with anything?	❑	❑
If Yes, what did you use to relieve it? _____		
20. Do you have pain with intercourse?	❑	❑
21. Are you worried you might have a sexually transmitted disease?	❑	❑
22. Do you examine your breasts?	❑	❑
If Yes, have you noticed any changes in your breasts?	❑	❑
do you have any discharge from your breasts?	❑	❑
23. Since your last visit, have you, or anyone in your family had any recent operations, serious illnesses or injuries?	❑	❑
If Yes, describe _____		
24. Are there any other gynecologic or non-gynecologic problems you would like to discuss with me?	❑	❑
If Yes, describe if you wish:		

25. Please make a note of any *changes* to lines (a), (b), or (c) that have occurred since your last visit here.

a) Name_____ Phone_____

b) Address _____

c) Employment_____ Medical Insurance_____ Policy No._____

Today's Date_____ Your Signature_____