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 medications? _____	☐	☐
	If Yes, which medications (s)? _____	☐	☐
3.	Have you been diagnosed with a new medical condition since your last visit? _____	☐	☐
	If yes, please explain? _____	☐	☐
4.	Are you currently taking any medication? _____	☐	☐
	If Yes, list the medications (s) you are currently taking: _____	☐	☐
5.	Are you currently taking any non-prescribed or sheet drugs? _____ If Yes, what type and amount do you consume on a daily basis? type _____-_____/day	☐	☐
6.	Do you currently drink alcohol? _____ If yes, what type and amount do you consume in a typical day? type _____-_____/day	☐	☐
7.	Do you currently smoke? _____ If yes, how much do you smoke on a daily basis? _____/day	☐	☐
8.	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.

9.	Please indicate your present method of birth control ☐ none, or _____		
10.	Do you think you might be pregnant? _____	☐	☐
11.	Your last menstrual period began on _____/_____/_____		
12.	Have you noticed anything different about your periods? _____	☐	☐
13.	How long is it between the start of one period and the start of the next? _____ days or _____ months		
14.	How long do your periods last? _____days		
15.	Write in the number and size of tampons and/or pads that you use on your "heaviest" day. _____ _____ tampons and/or _____ _____ pads		
16.	Do you skip periods? _____	☐	☐
17.	During or between periods, do you have pains/pressure in your lower back, abdomen or pelvis? _____	☐	☐
18.	Have you had any spotting and/or bleeding between periods? _____	☐	☐
19.	Write in any other changes related to your periods_____		
20.	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? _____	☐	☐
21.	Do you have pain with intercourse? _____	☐	☐
22.	Are you worried you might have a sexually transmitted disease? _____	☐	☐
23.	Do you examine your breasts? _____	☐	☐
	If Yes, have you noticed any changes in your breasts? _____	☐	☐
	Do you have any discharge from your breasts? _____	☐	☐
24.	Since your last visit, have you, or anyone in your family had any recent operations, serious illnesses or injuries? If yes, describe _____	☐	☐
25.	Are there any other gynecologic or non-gynecologic problems you would like to discuss with me? _____ If yes, describe if you wish:	☐	☐

26. 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 _____