

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? | <input type="checkbox"/> | <input type="checkbox"/> |
| If Yes, which medication(s)? _____ | | |
| 3. Are you currently taking any medication? | <input type="checkbox"/> | <input type="checkbox"/> |
| If Yes, list the medication(s) you are currently taking: _____ | | |
| 4. Are you currently taking any non-prescribed or street drugs? | <input type="checkbox"/> | <input type="checkbox"/> |
| If Yes, what type and amount do you consume on a daily basis? type _____, _____ / day | | |
| 5. Do you currently drink alcohol? | <input type="checkbox"/> | <input type="checkbox"/> |
| If Yes, what type and amount do you consume in a typical day? type _____, _____ / day | | |
| 6. Do you currently smoke? | <input type="checkbox"/> | <input type="checkbox"/> |
| If Yes, how much do you smoke on a daily basis? _____ / day | | |
| 7. How much caffeine do you consume on a daily basis? <input type="checkbox"/> none <input type="checkbox"/> 1-2 cups <input type="checkbox"/> 3-4 cups <input type="checkbox"/> 5+ 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. <input type="checkbox"/> None, or _____ | | |
| 9. Do you think you might be pregnant? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Your last menstrual period began on ____ / ____ / ____ | | |
| 11. Have you noticed anything different about your periods? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. During or between periods, do you have pains/pressure in your lower back, abdomen or pelvis? | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Have you had any spotting and/or bleeding between periods? | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Write in any other changes related to your periods _____ | | |
| 19. Have you noticed any unusual vaginal odor, discharge or itching? | <input type="checkbox"/> | <input type="checkbox"/> |
| If Yes, how long has this been happening? _____ | | |
| how often does it happen? _____ | | |
| have you tried to relieve it with anything? | <input type="checkbox"/> | <input type="checkbox"/> |
| If Yes, what did you use to relieve it? _____ | | |
| 20. Do you have pain with intercourse? | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Are you worried you might have a sexually transmitted disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Do you examine your breasts? | <input type="checkbox"/> | <input type="checkbox"/> |
| If Yes, have you noticed any changes in your breasts? | <input type="checkbox"/> | <input type="checkbox"/> |
| do you have any discharge from your breasts? | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Since your last visit, have you, or anyone in your family had any recent operations, serious illnesses or injuries? | <input type="checkbox"/> | <input type="checkbox"/> |
| If Yes, describe _____ | | |
| 24. Are there any other gynecologic or non-gynecologic problems you would like to discuss with me? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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~~ _____ ~~Phone No.~~ _____

Today's Date: _____ Your Signature _____