Return GYN Annual Visit Patient History

Date: ____/____/_____

Patient Name: _____ DOB: _____ Age: _____

Do you have any problems to discuss today? (please explain): _____

_____

Note: *Under most insurance plans, addressing problems is not part of an annual well-woman visit, so a co-pay may be required, or a return visit may be needed to allow adequate time to manage your concerns.*

Marital Status: _____ Allergies (& reaction): _____

Please list all your medications or attach your own list, include dosage and reason.

_____ _____ _____

_____ _____ _____

Since your last visit here, have you:

Yes ( ) No ( ) Seen a primary care provider?
Yes ( ) No ( ) Had any lab tests?
Yes ( ) No ( ) Had any changes in your health or medical history?
Yes ( ) No ( ) Had any surgeries or hospitalizations?
Yes ( ) No ( ) Had any changes in your personal, social, or family history?

Please explain any yes answers: _____

_____

Do you smoke or vape? Yes ( ) No ( ) If yes, please give details. _____
Do you exercise? Yes ( ) No ( ) Frequency/Type: _____
Have you been vaccinated against HPV (Gardasil)? Yes ( ) No ( )
When was first day of your last menstrual period? _____

How many days does your bleeding last? _____

How frequent are your periods? _____

Are your periods painful? Yes ( ) No ( ) Associated with extreme PMS? Yes ( ) No ( )

Are your periods heavy? Yes ( ) No ( ) Does the flow have blood clots? Yes ( ) No ( )

Do they affect your social, athletic, or sexual activity or cause you to miss work? Yes ( ) No ( )

How many total pregnancies have you had? ____ How many live births? _____
Do you wish to have children (or more children) in the future? Yes ( ) No ( ) Unsure ( )
What method of birth control are you using? _____ Satisfaction with Method? Yes No
Would you like to be tested for sexually transmitted diseases today? Yes ( ) No ( )
Last PAP: _____ Last mammogram: _____
Are you doing self-breast exams? Yes ( ) No ( )
PROVIDER REVIEWED DATE AND INITIALS: ____/____/_____ _____