Return GYN Problem Visit Patient History

Date: ____/____/_____

Patient Name: _____ DOB: _____ Age: _____

Please briefly explain the reason for your visit: _____

_____

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

_____ _____ _____

_____ _____ _____

Allergies _____

First day of last menstrual period ___/___/_____

Total # pregnancies: ____ Total # births: _____

Birth control method: _____

Any new medical conditions or surgeries since your last visit? _____

When did your problem start? _____

Have you tried any treatments? Did this help? _____

Is there anything that makes your condition better? _____

Is there anything that makes your condition worse? _____

Have you had any exposure to new products? _____

PROVIDER REVIEWED DATE AND INITIALS: ____/____/_____ _____