ADRIATICA
Women's Health
OB/GYN

Interval Gynecological History

Print Name _____ Date of Birth _____ Date _____

1. What is the reason for your visit today? _____
2. Any medication allergies? _____
3. Current medications: _____
4. List any current non-prescription or street drugs: _____
5. Do you drink alcohol? ---------- Y N Type _____ Daily amount _____
6. Do you smoke?---------- Y N Daily amount _____
7. How much caffeine do you consume on a daily basis? _____
8. Please indicate your present method of birth control: _____
9. Are you currently pregnant?----------Y N Maybe
10. What was the first day of your last menstrual period? _____ 11. Do you skip periods?----- Y N
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? _____ Length of period _____
14. Write in the number and size of tampons and/or pads that you use on your "heaviest" day: _____ tampons _____ pads
15. During or between periods, do you have pains and/or pressure in your lower back, abdomen or pelvis?---------- Y N
    If so, please describe: _____
16. Have you had any spotting and/or bleeding between periods?---------- Y N
    If so, please describe: _____
17. Have you noticed any unusual vaginal odor, discharge or itching?---------- Y N
    If so, how long has this been happening? _____ What have you tried to relieve the symptoms? _____
    Describe the problem: _____
18. Do you have any problems with urine leakage?---------- Y N
19. Are you sexually active? Y N Are you worried you might have a sexually transmitted disease? Y N
20. Do you have pain with intercourse?---------- Y N
    If so, please describe: _____
21. Do you examine your breast? Y N Do you have any discharge from your breasts? Y N
    Describe any concerns and/or changes: _____
22. Date of your last Mammogram? _____Where?_____
23. Date of your last Bone Density Test?_____Where?_____
24. Date of your last Colonoscopy?_____Where?_____
25. Since your last visit, have you or anyone in your family had any recent operations, serious illnesses or injuries? Y N
    If so, please describe: _____
26. Are there any other gynecologic or non-gynecologic problems you would like to discuss with me?---------- Y N
    If so, please list: _____
27. Name, address & ph# of preferred pharmacy: _____

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