Women's OB/Gyn Center

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NAME:______________________________ AGE:________________

MAIN REASON FOR YOUR VISIT
TODAY:____

HISTORY OF PREGNANCIES:

YEAR:	TERM OR PREMATURE		VAGINAL OR CESAREAN DELIVERY	
_______	☐	☐	☐	☐
_______	☐	☐	☐	☐
_______	☐	☐	☐	☐
_______	☐	☐	☐	☐
_______	☐	☐	☐	☐

DATE OF LAST MENSTRUAL PERIOD:__________HOW LONG DO THEY LAST?:__________

DO YOU EXPERIENCE ANY OF THE FOLLOWING:

	YES	NO
BLEEDING BETWEEN PERIODS:	☐	☐
HEAVY PERIODS:	☐	☐
PAINFUL PERIODS:	☐	☐
EXCESSIVE DISCHARGE BETWEEN PERIODS:	☐	☐
VAGINAL ITCHING:	☐	☐
SPOTTING AFTER INTERCOURSE:	☐	☐
PAINFULL INTERCOURSE:	☐	☐
PAIN WITH URINATION:	☐	☐
FREQUENT URINATION:	☐	☐
PRESSURE AT THE END OF URINATING:	☐	☐
URGE TO GO:	☐	☐
LOSS OF URINE WITH LAUGH/COUGH:	☐	☐
BOWEL PROBLEMS:	☐	☐

HOW OFTEN DO YOU EXPERIENCE URINARY LEAKAGE?

A) NEVER
B) LESS THAN ONCE A MONTH
C) ONE OR SEVERAL TIMES A MONTH
D) ONE OR SEVERAL TIMES PER WEEK
E) EVER DAY AND/OR NIGHT

HOW MUCH URINE DO YOU LOSE EACH TIME?

A) NONE
B) 1 DROP OR LITTLE
C) MORE/EXCESSIVE

WHAT BIRTH CONTROL DO YOU USE:______________________________

HOW LONG HAVE YOU USED THIS METHOD?___________________________

LIST THE MEDICATIONS YOU ARE CURRENTLY TAKING:____

ARE YOU ALLERGIC TO ANY MEDICATIONS:______________________________

LIST ANY OPERATIONS YOU HAVE HAD:

YEAR:	OPERATION:
______	____________________________
______	____________________________
______	____________________________
______	____________________________

YEAR OF YOUR LAST PAP SMEAR__________ MAMMOGRAM________________

HAVE YOU OR YOUR FAMILY EVER HAD THE FOLLOWING:

	YOU	**FAMILY**	**NO**
CANCER(LIST TYPE)____________	☐	☐	☐
DIABETES	☐	☐	☐
HIGH BLOOD PRESSURE	☐	☐	☐
HEART DISEASE	☐	☐	☐
VENEREAL DISEASE	☐	☐	☐
EPILEPSY	☐	☐	☐
THYROID PROBLEM	☐	☐	☐
KIDNEY DISORDER	☐	☐	☐
DISABILITIES	☐	☐	☐

DO YOU HAVE ANY MEDICAL PROBLEMS NOT LISTED THAT WE SHOULD BE AWARE OF?

____

DOYOU SMOKE?: ☐ YES ☐ NO IF YES, HOW MANY PER DAY?________AGE STARTED____
DO YOU DRINK?: ☐ YES ☐ NO IF YES, HOW OFTEN?______________
DO YOU USE STREET DRUGS?: YES ☐ NO ☐

In the past, was your level of sexual desire or interest good and satisfying to you?
Yes______ No______

Has there been a decrease in your level of sexual desire or interest?
Yes______ No______

Are you bothered by your decreased level of sexual desire or interest?
Yes_____ No______

Would you like your level of sexual desire or interest to increase?
Yes_____ No______