

## *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. When was your last Mammogram? \_\_\_\_\_
23. 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: \_\_\_\_\_
24. Are there any other gynecologic or non-gynecologic problems you would like to discuss with me?----- Y      N  
If so, please list: \_\_\_\_\_
25. Name, address & ph# of preferred pharmacy: \_\_\_\_\_  
\_\_\_\_\_