Beach Cities Midwifery & Women's Healthcare

INTERVAL GYNECOLOGY HISTORY

Patient's Name _____

Date of Birth _____

In order to provide you with more effective care, there is certain basic information about your recent history that will help us. The few minutes you spend on these questions will provide us with important items that contribute to your health care.

The reason for your visit today is: _____

	YES	NO
1. Since your last visit here, have you acquired any allergies to medication?	☐	☐
If yes, which medications(s) _____		
2. Are you currently taking any medication?	☐	☐
If yes, list the medication(s) you are currently taking: _____		
3. Are you currently taking any non-prescription or street drugs?	☐	☐
If yes, what type and amount do you consume on a daily basis? Type _____, _____/day		
4. Do you currently drink alcohol?	☐	☐
If yes, what type and amount do you consume in a typical day? Type _____, _____/day		
5. Do you currently smoke?	☐	☐
If yes, how much do you smoke on a daily basis? _____ / day		
6. How much caffeine do you consume on a daily basis? ☐ none ☐ 1-2 cups ☐ 3-4 cups ☐ 5+ cups		

If you have not begun to menstruate, are past menopause, or have had a hysterectomy, skip to question 19.

7. Please indicate your present method of birth control. ☐ none, or _____		
8. Do you think you might be pregnant?	☐	☐
9. When was the first day of your last menstrual period _____		
10. Have you noticed anything different about your periods? _____	☐	☐
11. How many days is it between the start of one period and the start of the next? _____ days		
12. How many days do your periods last? _____ days		
13. Write in the number and size of tampons and/or pads that you use on your "heaviest" day.		
_____ Tampons and/or _____ pads		
14. Do you skip periods?	☐	☐
15. During or between periods, do you have pains/pressure in your lower back, abdomen or pelvis?	☐	☐
16. Have you had any spotting and/or bleeding between periods?	☐	☐
17. Write in any other changes related to your periods _____		
18. Have you had any changes in your sexual partner since your last visit?	☐	☐
19. Have you noticed any unusual vaginal odor, discharge or itching?	☐	☐
If yes, how long has this been happening? _____		
How often does it happen? _____		
Have you tried to relieve it with anything? _____		
If yes, what have you used to relieve it? _____		
20. Do you have pain with intercourse?	☐	☐
21. Are you worried you might have a sexually transmitted disease?	☐	☐
22. Do you examine your breasts?	☐	☐
If yes, have you noticed any changes in your breasts?	☐	☐
Do you have any discharge from your breasts?	☐	☐
23. Since your last visit, have you had any recent operations, serious illnesses or injuries?	☐	☐
If yes, describe _____		
24. Since you last visit, have there been any changes in your family history, such as, diabetes, heart disease, osteoporosis, stroke, alzheimer's _____		
25. Are you currently being threatened by physical, emotional or verbal abuse?	☐	☐
26. Are there any other gynecologic problems you would like to discuss with me?	☐	☐
If yes, describe if you wish:		

27. Has there been any change in your address? ☐ No ☐ Yes If yes, please provide your new address and phone number

_____

_____

28. Has there been any change in your insurance since your last visit? ☐ No ☐ Yes If yes, please provide your new insurance information _____

Today's date: _____ Your signature _____

Please complete the second side of the form

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Are you having problems with any of the following:

No	Yes	If yes, please describe
☐	☐	Eyes, ears, nose, throat _____
☐	☐	Chest _____
☐	☐	Heart _____
☐	☐	Abdomen _____
☐	☐	Back _____
☐	☐	Arms/Legs _____
☐	☐	Elimination _____
☐	☐	Other _____

Are there any other concerns you would like to discuss with me? If yes, describe please _____

_____

_____

_____