



Returning Patient History Form

Name _____

Date of Visit _____

Date of Birth _____

Last Menstrual Period _____

Periods are regular irregular absent

Pain with periods Heavy periods

I have had an abnormal Pap smear in the past no yes

Number of **new** sexual partners since your last visit _____

Contraception (please circle): none natural family planning diaphragm condoms birth control pills
contraceptive gel/foam patch Nuvaring® DepoProvera® IUD
tubal ligation Essure® Nexplanon® Implanon® vasectomy

Smoking no yes how much? _____ **Exercise** frequency _____ x per week

Current Medications none _____

Supplements: Multivitamin Calcium Vitamin D Fish oil Folic Acid

Allergies to medications _____

Any new medical conditions since your last visit here? _____

Any new surgical procedures since your last visit here? _____

Any new family history since your last visit here? _____

Are you currently experiencing any of the following? (Please check **all** that apply.)

- | | | |
|--|---|--|
| <input type="checkbox"/> Chills | <input type="checkbox"/> Fever | <input type="checkbox"/> Vision Changes |
| <input type="checkbox"/> Ear Infection | <input type="checkbox"/> Sore Throat | <input type="checkbox"/> Shortness Of Breath |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Cough | <input type="checkbox"/> Palpitations |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Irregular Heart Beat | <input type="checkbox"/> Nausea or Vomiting |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Incontinence |
| <input type="checkbox"/> Pain With Urination | <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Sexual Problems |
| <input type="checkbox"/> Change In Vaginal Discharge | <input type="checkbox"/> Vaginal Itching | <input type="checkbox"/> Weight Change |
| <input type="checkbox"/> Cold Intolerance | <input type="checkbox"/> Heat Intolerance | |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Depression | |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Tremors | |
| <input type="checkbox"/> Change In Color/Size Of Moles | <input type="checkbox"/> Rashes | <input type="checkbox"/> Hives |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Joint Pain | <input type="checkbox"/> Muscle Aches |
| <input type="checkbox"/> Bleeding | <input type="checkbox"/> Easy Bruising | <input type="checkbox"/> Blood Clotting |
| <input type="checkbox"/> None of the above | | |