

**Return GYN Annual Visit Patient History**

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_

Do you have any problems to discuss today? (please explain): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Note**: *Under most insurance plans, addressing problems is not part of an annual well-woman visit, so a co-pay may be required, or a return visit may be needed to allow adequate time to manage your concerns.*

Marital Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Allergies (& reaction): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list all your medications or attach your own list, include dosage and reason.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Since your last visit here, have you:**

Yes ( ) No ( ) Seen a primary care provider?

Yes ( ) No ( ) Had any lab tests?

Yes ( ) No ( ) Had any changes in your health or medical history?

Yes ( ) No ( ) Had any surgeries or hospitalizations?

Yes ( ) No ( ) Had any changes in your personal, social, or family history?

Please explain any yes answers: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you smoke or vape? Yes ( ) No ( ) If yes, please give details. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you exercise? Yes ( ) No ( ) Frequency/Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you been vaccinated against HPV (Gardasil)? Yes ( ) No ( )

When was first day of your last menstrual period? \_\_\_\_\_\_\_\_\_\_\_\_\_

How many days does your bleeding last? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

How frequent are your periods? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are your periods painful? Yes ( ) No ( ) Associated with extreme PMS? Yes ( ) No ( )

Are your periods heavy? Yes ( ) No ( ) Does the flow have blood clots? Yes ( ) No ( )

Do they affect your social, athletic, or sexual activity or cause you to miss work? Yes ( ) No ( )

How many total pregnancies have you had? \_\_\_\_ How many live births? \_\_\_\_\_\_\_\_

Do you wish to have children (or more children) in the future? Yes ( ) No ( ) Unsure ( )

What method of birth control are you using? \_\_\_\_\_\_\_\_\_\_\_ Satisfaction with Method? Yes No

Would you like to be tested for sexually transmitted diseases today? Yes ( ) No ( )

Last PAP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last mammogram: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you doing self-breast exams? Yes ( ) No ( )

PROVIDER REVIEWED DATE AND INITIALS: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_