



DATE: NAME: DATE OF BIRTH: AGE:

PREFERRED NAME (How should we address you?): YOUR PROFESSION:

WHY ARE YOU HERE TODAY?

CURRENT MEDICATIONS, HERBS, VITAMINS &/OR SUPPLEMENTS (include frequency and doses, if known):

ALLERGIES (to medications or food) [ ] NKDA YOUR PRIMARY CARE PROVIDER: [ ] Send today's visit note to PCP

OBSTETRICAL/GYNECOLOGICAL HISTORY

MENSTRUAL HISTORY (skip if you are postmenopausal or have had a hysterectomy)

First day of last period: # of days between periods: (from start of one to start of next menses) # of days you bleed: Amount of bleeding? [ ] heavy [ ] medium [ ] light [ ] Menses painful Any problems with period, questions or concerns?:

SEXUAL HISTORY

I have sex with: [ ] male partner(s) [ ] female partner(s) [ ] either/both male &/or female partner(s) [ ] MTF partner(s) [ ] FTM partner(s) [ ] not active

I have had or my partner(s) has had new partner(s) since last visit: [ ] no [ ] yes [ ] unknown [ ] have not been active With sexual activity, do you have: [ ] pain [ ] bleeding [ ] I want safer sex information Please list any questions/concerns:

Date and site of last Pap and/or HPV, if not done here at VTGyn: [ ] done here [ ] Pap/HPV results:

PREGNANCY HISTORY

Pregnant since last visit? [ ] no [ ] yes If yes, please note date(s) and outcome(s) of pregnancy(ies):

CONTRACEPTIVE HISTORY [ ] N/A

If you use a birth control method(s), what do you use? Questions/problems with method? [ ] no [ ] yes Interested in changing birth control methods? [ ] no [ ] yes Please list questions/problems:

MENOPAUSE AND BEYOND [ ] N/A

Age you stopped having periods: Problems/concerns? [ ] no [ ] yes - Please describe: Taking hormone therapy or other remedies? [ ] no [ ] yes If so, what are you taking? (List herbs, meds, etc. below.)

MEDICAL HISTORY

Since last visit here, any changes in gynecologic, medical and/or family history? [ ] no [ ] yes Please list:

Since last visit here, any hospitalizations, surgeries, accidents or serious illness? [ ] no [ ] yes Please list:



NAME:

DATE OF BIRTH:

TODAY'S DATE:

REVIEW OF SYSTEMS

Do you have any current problems with (check all that apply and explain in spaces provided):  No current problems

Table with 2 columns: System (checkbox), Description. Rows include: General wellness, Skin, Head/Eyes/Ears/Nose/Throat, Breasts, Heart, Lungs, Bladder, Bowel, Muscles/Joints, Neurologic symptoms, Psychiatric symptoms, Endocrine (e.g. thyroid), Other.

HEALTH, NUTRITION, PREVENTION

I exercise \_\_\_ per week. Types of exercise I do:

I eat a well balanced diet:  no  yes I eat \_\_\_ servings of fruits and vegetables per day (serving = 1/2 cup).

Specific diet? Please describe: \_\_\_\_\_

I take calcium &/or consume calcium rich foods  no  yes What sources and how much? \_\_\_\_\_

I take Vitamin D or get it from food  no  yes How much and how often? \_\_\_\_\_

I drink alcohol  no  yes What kind, how much, and how often? \_\_\_\_\_

I smoke tobacco products  no  yes How much and how often? \_\_\_\_\_  Ex-smoker (Quit: \_\_\_\_\_)

I use other drugs  no  yes Which one(s) and how often? \_\_\_\_\_

Since last visit have you had:

Cholesterol test?  no  yes When? \_\_\_\_\_ Where? \_\_\_\_\_ Result? \_\_\_\_\_

Mammogram?  no  yes When? \_\_\_\_\_ Where? \_\_\_\_\_ Result? \_\_\_\_\_

Colonoscopy?  no  yes When? \_\_\_\_\_ Where? \_\_\_\_\_ Result? \_\_\_\_\_

Bone density/DXA?  no  yes When? \_\_\_\_\_ Where? \_\_\_\_\_ Result? \_\_\_\_\_

Other(s): \_\_\_\_\_  no  yes When? \_\_\_\_\_ Where? \_\_\_\_\_ Result? \_\_\_\_\_

I am concerned about my safety in my relationship:  no  yes

I have written advanced directives:  no  yes

VACCINATION RECORD

- I have had the tetanus vaccine within the last 10 years
 I have had measles, mumps, and rubella or was vaccinated
 I have had the HPV vaccine series as a child, teen or young adult

- I have had chicken pox or was vaccinated
 I have had meningitis vaccine
 I have had hepatitis B vaccinations
 If over 60, I have had the shingles vaccine
 If over 65, I have had Pneumovax vaccine

I would like a written summary of today's visit