Women For Women OBGYN
Returning Patient

Name: _____
Date of Birth: _____

Are you taking any medications? ☐ yes ☐ no

If yes, please list the medications (including over the counter medications, supplements, vitamins):

_____
_____
_____
_____
_____
_____
_____

Do you have any allergies? ☐ yes ☐ no

If yes, please list allergy and type of reaction:

_____
_____
_____
_____
_____
_____
_____

Reason for today's visit: _____

Since your last visit, have you been diagnosed with any new medical condition? ☐ yes ☐ no

_____

Since your last visit, have you had any surgeries? ☐ yes ☐ no

_____

Since your last visit, have there been any changes to your family's medical history? ☐ yes ☐ no

_____

Date of last period? _____

Are your periods regular? ☐ yes ☐ no Heavy? ☐ yes ☐ no Painful? ☐ yes ☐ no

Are you sexually active? ☐ Never ☐Not currently ☐ Yes

If yes, how many current partners do you have? _____

Do you have sex with ☐ men ☐ women ☐both

Are you currently using contraception (birth control)? ☐ yes ☐ no

Are you interested in contraception (birth control)? ☐ yes ☐ no

Last Pap smear _____ Last colonoscopy _____

Last Mammogram _____ Last bone density _____

Signature of patient: _____ _____ Date: _____

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Name: _____
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Since your last visit, have you had any new pregnancies, including miscarriages, abortions, or ectopic pregnancies?

If yes, please list details below:

Date of Delivery	Type of Delivery	# of weeks	Sex	Baby weight	Epidural?	Complications	Place of delivery

Tobacco Use: ☐ never ☐Current ____#of cigarettes per day ____#of years ☐ Former, year quit _____

Any Alcohol use? ☐ yes ☐ no If yes, average # of drinks per day? _____

Do you use recreational drugs? ☐ yes ☐ no If yes, what type and when was last use?_____

How many times per week do you exercise? _____

Have you been hit, kicked, punched or otherwise hurt by someone in the past year? ☐ yes ☐ no

Are you safe in your current relationship? ☐ yes ☐ no

Is there a partner from a previous relationship that is making you feel unsafe now? ☐ yes ☐ no

What do you do for work? _____

Are you ☐ married ☐ single ☐ divorced ☐ separated ☐ widowed

Who do you live with? _____

If it were medically necessary, would you accept a blood transfusion? ☐ yes ☐ no

Please check any symptoms you are currently experiencing:

- ☐ Fatigue
- ☐ Unexplained weight loss
- ☐ Unexplained weight gain
- ☐ Fever
- ☐ Breast mass
- ☐ Breast discharge
- ☐ Easy bruising
- ☐ Chest Pain
- ☐ Shortness of breath
- ☐ Nausea/Vomiting
- ☐ Leg swelling
- ☐ Frequent headaches
- ☐ Bleeding from rectum
- ☐ Blood in urine
- ☐ Pain with urination
- ☐ Leakage of urine
- ☐ Painful intercourse
- ☐ Bleeding after intercourse
- ☐ Bleeding between periods
- ☐ Vaginal itch

Signature of patient: _____ _____ Date: _____