RICHMOND GYNECOLOGY, P.C.

DATE OF VISIT: _____ REASON FOR VISIT: _____

PATIENT NAME: _____

LIST CURRENT MEDICATIONS: _____

_____

ALLERGIES TO MEDICATION (DESCRIBE REACTION): _____

_____

PLEASE LIST ALL VACCINES: _____

_____

GYNECOLOGIC HISTORY:

NUMBER OF PREGNANCIES:___NUMBER OF LIVING CHILDREN:___AGE AT FIRST PERIOD:___CRAMPS:YES__NO__

DATE OF LAST PERIOD:_____LENGTH OF FLOW:_____INTERVAL BETWEEN PERIODS:_____

RECENT CHANGES:_____

SEXUALLY ACTIVE: YES_____NO_____ EVER HAD SEX: YES_____NO_____

NUMBER OF PARTNERS (LIFETIME):_____ PARTNERS ARE: MEN_____WOMEN_____BOTH_____

CURRENT METHOD OF CONTRACEPTION:_____PAST CONTRACEPTIVE HISTORY_____

DATE OF LAST MAMMOGRAM:_____WHERE:_____

YOUR MEDICAL HISTORY:

___HEART DISEASE___HIGH BLOOD PRESSURE___DIABETES___MITRAL VALVE PROLAPSE___NONE___OTHER___

ANY HISTORY OF CANCER:___BREAST___OVARIAN___UTERUS___OTHER:_____

LAST COLORECTAL SCREENING:_____SURGICAL HISTORY:_____

SOCIAL HISTORY: ___DRUGS___DRINK___SEXUAL ABUSE___SMOKE___HOW LONG___PACKS PER DAY___

COUNSELLED INFORMATION GIVEN:_____

FAMILY MEDICAL HISTORY: ___HEART DISEASE___HIGH BLOOD PRESSURE___DIABETES___NONE___OTHER___

FAMILY CANCER HISTORY: ___BREAST___OVARIAN___UTERUS___COLON___NONE___OTHER_____

NURSE INTERVIEW FOR PRESENT ILLNESS: _____

_____

_____

PHYSICIAN INTERVIEW: _____

_____

_____