GYN FOLLOW-UP / PROBLEM VISIT

NAME:_____ **BIRTHDATE:**_____

PREFERRED PHONE #:_____ **Home/ Cell/ Work/ Other OK to leave a Message? Yes / No**

SECONDARY PHONE #:_____ **Home/ Cell/ Work/ Other OK to leave a Message? Yes / No**

Which doctor are you here to see? (Circle One) Kinder / Phillips / Runnels / Hirsch / Bunton

REASON FOR VISIT: _____

_____

PREFERRED PHARMACY (NAME/STREET/PHONE#):

_____

Please allow at least 4 business days for refills to be called in.

****The pharmacy that you list as preferred is where all your meds from this office will be called in, unless otherwise noted.***

DO YOU HAVE ANY ALLERGIES? (Circle One) Yes / No If yes, list allergy and reaction:

_____

_____

List any medications you are currently taking, including vitamins and supplements:

Name / Strength/ Frequency:	Name / Strength/Frequency:

Date of last period:_____ (Check if applicable) □ Hysterectomy □ Menopause

Current form of Birth Control:_____ Date of last pap smear:_____ Normal / Abnormal

Are you sexually active? Yes / No Date of last mammogram:_____

Do you have any new medical information or surgeries to report since your last visit to our clinic?

_____

_____

Is there any new family history since your last visit?_____

Current marital status: (Circle one) Single / Married / Divorced / Widowed / Separated / Life Partner

Do you drink alcohol? (Circle one) Never / Rarely / Socially

Do you drink caffeine? Yes / No How many cups per day? _____

Do you smoke? Yes / No How many daily? _____

Signature:_____ Date:_____