PROBLEM/PROCEDURE VISIT

BP:_____ / _____
Wt:____________
Ht:____________
Temp:__________
u/a:____________

Date:___________ Name:____________________________________ Age______
D.O.B.__________ Date last period began:______________________
Allergies____

What are you scheduled for today? *(Check all that apply)*
☐ Problem visit ☐ Procedure ☐ Mammogram ☐ Ultrasound ☐ Bone Density

Reason for today's visit____

(If applicable, please complete below)
Describe your symptoms:
____
When did those symptoms begin:
____
What treatments have you tried?
____

☐ Married ☐ Single ☐ Heterosexual ☐ Lesbian
How many times have you been Pregnant?_________ How many children do you have?_________
Are you trying to avoid pregnancy? ☐ Yes ☐ No If you are preventing pregnancy, which method are you using?____________________________ *(Please include brand of OCPS/IUD/sterilization method if appropriate)*

All current Medications *(Please include dosages)*:
____
____

Past Gyn Surgeries:____
____

Please describe any changes in personal, social or health status since your last visit:
____
____