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## GYNECOLOGY VISIT

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

When was the first day of your last menstrual period? \_\_\_\_\_ Was it normal?  Yes  No

Why are you here today? \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

Have you had any illness since your last visit?  Yes  No

Colds  Sore Throat  Virus  Other: \_\_\_\_\_

Have other members of your family had any illness?

Colds  Sore Throat  Virus  Other: \_\_\_\_\_

What medications/drugs are you taking? *(Please list)*

Over-the-counter drugs List: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Prescription drugs List: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Other List: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

What do you drink?  
 Coffee Number of cups per day \_\_\_\_\_  
 Soda Number per day \_\_\_\_\_  
 Alcohol Number of drinks per day \_\_\_\_\_  
 Other Number per day \_\_\_\_\_

Do you smoke?  Yes  No How much? \_\_\_\_\_

\_\_\_\_\_  
 Patient Signature

\_\_\_\_\_  
 Date