MARYSVILLE OBSTETRICS & GYNECOLOGY, INC.

Name: ____________________ Birth Date: _________ Today's Date: ________

Reason for visit: ____________________

Date of your last menstrual period? ____________________ Was it normal? ____________________

Date of your last pap smear? ____________________ Was it normal? ____________________

Date of your last mammogram? ____________________ Was it normal? ____________________

Are you sexually active now? ____________________ Is it normal? ____________________

Have you recently had sex with a new partner? ____________

What method of birth control do you currently use? ____________________

Do you douche? Yes ❑ No ❑ If yes, how often? ____________________

Have you ever been diagnosed with any of the following? If yes, give approximate date.

❑ Yeast infection ________________ ❑ Bacterial vaginosis _________ ❑ Trichomoniasis ___________

❑ Gonnorrhea ________________ ❑ Chlamydia ________________ ❑ Syphilis ________________

❑ Human Papilloma Virus (or genital warts) ______________ ❑ HIV/AIDS ________________ ❑ Herpes ________________

Since your last exam, have you had any problems with:

	Yes	No
Your menstrual cycles?	❑	❑
Irregular bleeding?	❑	❑
Cramps with your period?	❑	❑
Abnormal vaginal discharge?	❑	❑
Pelvic/Abdominal Pain?	❑	❑
Other?__________________	❑	❑
Breasts?	❑	❑
Change in bowel habits?	❑	❑
Any urinary problems, burning or frequency?	❑	❑
Physical/Mental/Sexual abuse?	❑	❑
Urinary leakage?	❑	❑

Since your last visit, have you had any: (if so, please explain)

	Yes	No	
Medical problems?	❑	❑	____________________
Sexual problems?	❑	❑	____________________
Dental problems?	❑	❑	____________________
Surgeries?	❑	❑	____________________
Change in family history?	❑	❑	____________________
Plans to attempt pregnancy THIS year?	❑	❑	____________________

What prescriptions or over-the-counter medications do you take on a regular basis (include vitamins)?

____

Birth Control Pills? _______What brand?____________________ How many years? ___________

Hormone Replacement Therapy? _________What brand(s)?____________________

What kind of schedule do you follow?____________________

	Yes	No	
Do you smoke?	❑	❑	If yes, how much?____________________
Do you drink alcohol?	❑	❑	If yes, how much?____________________
Do you drink caffeine?	❑	❑	If yes, how much?____________________
Do you use marijuana, cocaine or other street drugs?	❑	❑	
Do you get calcium in your diet?	❑	❑	How?____________________
Do you do self-breast exams?	❑	❑	Any problems? ____________________

How often do you exercise? ____________________For how long at a time? ____________________

What type of exercise? ____________________

Are there any other problems or issues you would like to discuss today? ____________________

Physician signature ____