Interval Patient History

Name: _____ D.O.B _____ Age: _____ Date: _____

The following information will help us update your personal health record. Please complete the following as accurately as possible.

Describe any major medical conditions you have been treated for since your last visit.

_____

_____

Describe any surgeries you have had since your last visit.

_____

Are you allergic to any medication? _____ If yes, please list the names of the medicines and the type of reaction you experienced. _____

List any and all medications (including vitamins and herbs you are currently taking, as well as the dosage and reason for taking.

_____

_____

When was your last pap smear? _____ Result? _____

When was your last mammogram? _____ Result? _____

Do you perform monthly self-breast exams? _____

Do you have any relatives that have ever been diagnosed with or treated for (a) breast cancer, (b) uterine cancer, (c) ovarian cancer, (d) cervical cancer, or (e) colon cancer (Please circle any that apply). If you circled any of the types of cancer, please explain what your relationship is to that relative.

_____

Do you ever leak urine unintentionally? _____

Are you having sexual relations now? _____ If yes, have you or your partner(s) had sex with more than one person in the past six months? _____ Do you have spotting or bleeding after sexual relations? _____ Do you have any pain during or after sexual relations? _____ Is there anything about your sexual relationship you would like to discuss? _____

What (if any) type of birth control do you use? _____

Are you still having regular monthly periods? _____ If so, what was the date of your last menstrual cycle? _____ Is there anything about your menstrual period you would like to discuss? _____

Who is your Primary care Physician? _____

Please list any other issues you would like to discuss

_____

_____