Stanford HEALTH CARE

Los Olivos Women's Medical Group

Gynecology Visit

Name: ____ Last period: __________________

Reason for today's visit: New Patient Annual Related to surgery Other (describe below)

Please list any questions, symptoms, concerns or anything else that you would like to discuss:

Any changes since your last visit?

Periods: Regular Irregular Menopause Hysterectomy Ablation Mirena IUD Skyla IUD

Current contraception: ____

Current medications: ____

Parent's medical problems:

Mother: No problem or disability Health condition: ____

Father: No problem or disability Health condition: ____

Other doctors that you see: ____

Do you smoke? Yes No Never smoked Quit

How much alcohol do you consume each week? None Minimal Socially Daily

Can we leave messages on your cell or home phone? (circle preference) YES NO

Number of pregnancies: None _______ Full term:______ Preterm: _____ Other: ________________________________

Drug Allergies: None List: _______________________________________ Latex: Yes No

Occupation: __________________________________Marital status: _____ Partner's name: _____________________

Circle any of the following that you are **currently experiencing** **NONE**

General:	Extreme Fatigue	Depression	Fever	
	Weight gain or loss (greater than 10lbs in last year)		How much? _________	
	Heat intolerance	Cold intolerance		
Skin:	Change in mole	Rash		
Respiratory/Cardiac:	Shortness of breath	Cough	Chest pain	Palpitations
Breast:	Lump	Nipple discharge	Redness	
Gastrointestinal:	Abdominal pain	Black or bloody stools	Bloating	Diarrhea
	Constipation	Change in bowel movements	Vomiting	Nausea
Gynecologic:	Abnormal vaginal bleeding		Pain with bleeding	
	PMS Symptoms ____			
	Menopausal symptoms ____			
	Pain during intercourse		Pain with urination	
Urinary:	Loss of urine	Blood in urine		
	Urinary frequency	Urgency		
Musculoskeletal:	Muscle aches	Muscle weakness		
Neurologic:	Change in headaches	Numbness	Dizziness	

For Nursing and Doctors: Height ________Weight __________B/P __________