(For Office Use)
P: ✓ ☺ 👎

MRN:_____

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Returning Patient History Form

Name_____ **Date**_____**Reason for Visit**_____

Date of Birth_____ **First Day of Last Menstrual Period**_____

Primary Care Physician_____ **Pharmacy**_____

Periods are: ☐ Regular ☐ Irregular ☐ Absent ☐ Pain with Periods ☐ Heavy Periods

I have had an abnormal Pap smear in the past: ☐ No ☐ Yes

Number of ***NEW*** sexual partners since your last visit: _____ Marital Status (Optional): _____

Current Contraception: ☐None ☐Natural Family Planning ☐Diaphragm ☐Condoms

☐Birth Control Pills – Brand: _____ ☐Contraceptive Gel/Foam ☐Patch ☐NuvaRing

☐DepoProvera® ☐IUD ☐Tubal Ligation ☐Essure® ☐Nexplanon® ☐Implanon® ☐Vasectomy

Deliveries (#) : Vaginal___ C-Section___ Full-Term___ Pre-Term___ Miscarriages___ Ectopic___ Induced Abortion___

☐ **Alcohol:** Type _____ Frequency_____ ☐**Caffeine:** Type_____ Frequency_____

☐ **Smoking** How much? _____ **Exercise** Frequency:_____x per week

Current Medications: ☐None _____

_____

Supplements: ☐ Multivitamin ☐ Calcium ☐ Vitamin D ☐ Fish Oil ☐ Folic Acid

Medication Allergies and Reactions: _____

_____

List any new medical conditions since your last visit here: _____

_____

List any new surgical procedures since your last visit here: _____

_____

List any new family history since your last visit here: _____

_____

Are you **currently** experiencing any of the following? (Please check all that apply.)

☐Chills	☐Headache	☐Frequent Urination	☐Shortness of Breath
☐Ear Infection	☐Change in Color/Size of Moles	☐Vaginal Itching	☐Palpitations
☐Asthma	☐Bleeding	☐Heat Intolerance	☐Nausea or Vomiting
☐Chest Pain	☐Fever	☐Depression	☐Incontinence
☐Constipation	☐Sore Throat	☐Tremors	☐Sexual Problems
☐Pain with Urination	☐Cough	☐Rashes	☐Weight Change
☐Change in Vaginal Discharge	☐Irregular Heartbeat	☐Joint Pain	☐Hives
☐Anxiety	☐Cold Intolerance	☐Easy Bruising	☐Muscle Aches
☐Fatigue	☐Diarrhea	☐Vision Changes	☐Blood Clotting
☐***None of the Above***	☐Back pain	☐Abdominal Pain	

We want to know about your experience at our practice. Please provide your email address if you are willing to receive an email with a brief survey: _____