The OB-GYN Place
Todays Visit

Name:______________________________________ Age:__________

Today's Date:____________________

Since your LAST VISIT, we would like to hear how you are doing.

LMP:__________________ Could you be pregnant?:__________________
(Last Menstrual Period)

If you answered NO, please elaborate by circling one of the following:

Hysterectomy   Menopause   Post Menopause   Depo Provera   Birth Control Pills   Irregular Periods

	Circle One		Please Specify
1. Have you changed jobs?	Yes	No	____________________
2. Any problems with work?	Yes	No	____________________
3. Have you moved?	Yes	No	____________________
4. Any changes in your relationship with your partner?	Yes	No	____________________
5. Have there been any changes in your period?	Yes	No	____________________
6. Have you seen any other doctors in the past year?	Yes	No	____________________
7. Have you had any major illnesses or accidents this past year?	Yes	No	____________________
8. Have any family members had any major illnesses or accidents this year?	Yes	No	____________________

9. What do you use for birth control? ______________________________

10. Please list all medications you are taking, including herbals and over the counter medications:

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11. Do you have any questions or concerns?

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Please answer if you are over 35:

Date of last mammogram: ____________________
Any family history of Breast Cancer? ____________________
Date of your last stool test? ____________________

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