

Petoskey Gynecology & Infertility

FOLLOW-UP VISITS – YEARLY EXAMS

DATE _____

YOUR NAME _____ DOB _____ AGE _____

ANY GYN PROBLEMS? _____ IF SO, WHAT? _____

DATE OF LAST MENSTRUAL PERIOD? _____

HYST.? (Y) OR (N) POST MENOPAUSAL ? (Y) OR (N)

CURRENT MEDICATIONS _____

ANY NEW MAJOR ILLNESSES THIS YEAR? _____

ANY SURGERY IN THE PAST YEAR? _____

ANY RECENT HOSPITALIZATIONS? _____

ALLERGIES “ TO MED’S “? _____ LATEX ALLERGY? YES/NO

DO YOU SMOKE? _____ HOW MUCH? _____

DRINK ALCOHOL? _____ HOW MUCH? _____

CAFFEINE INTAKE? (i.e coffee, tea, pop) _____/day

CURRENT OCCUPATION _____

MARRIED? ___ SINGLE? ___ DIVORCED? ___ SEPARATED? ___ WIDOW? ___

DO YOU OR YOUR PARTNER USE ANYTHING TO PREVENT PREGNANCY?

_____ IF YES, WHAT? _____ VASECTOMY? _____ TUBAL LIGATION? _____

BLADDER PROBLEMS? _____

ANY NEW FAMILY ILLNESSES? _____

WHO IS YOUR PRIMARY CARE PROVIDER? _____

IF YOU’VE BEEN TO OTHER DOCTORS THIS YEAR, HAVE YOU HAD:

LAB WORK? _____ WHAT? _____

XRAYS? _____ WHAT? _____

BONE DENSITY TEST? _____

COLONOSCOPY? _____

MAMMOGRAM? _____

ANY OTHER THINGS YOU’D LIKE TO DISCUSS TODAY?
