Established GYN Office Visit

Name: _____ Date: _____

Allergies: _____

1) What brings you to our office today?

   → Problem visit (please explain)

   → Are you having any urinary symptoms such as burning with urination, urinary frequency, or urinary urgency? (Please explain)

   → Are you having any excessive or irregular vaginal bleeding?
   - No
   - Yes (please explain)

   → Do you think you may be pregnant? YES / NO
   - If you have menstrual cycles, what was the first day of you last menses?
   - What is your method of pregnancy prevention (in any)?

2) Have you had any changes to your personal health, surgeries or family health since your last visit at Athens OB/GYN?
   - No
   - Yes (please explain)

3) Current medicines: (or provide list):

NAME	STRENGTH	INSTRUCTIONS FOR DOSING