Women Partners
in OB/GYN

Problem/Episodic Visit Update Form

Name: _____ **Date:** _____ **Doctor:** _____

Date of Birth: _____ **1st day of your last menstrual period:** _____

Why are you seeing the doctor/nurse practitioner today? _____

(Please check all that apply to you **TODAY**)

	Yes		Yes
Constitutional		**Gynecological**	
Headache		Vaginal discharge	
Fatigue		Vaginal irritation/itching	
Fever/chills		Vaginal odor	
Weight gain		Vaginal dryness	
Weight loss		Irregular bleeding	
		Painful periods	
Breast		Painful sex	
Breast lumps		Pelvic pain	
Nipple discharge		Genital sores/bumps	
Breast pain		Sexual function concerns	
Gastrointestinal		**Peri/menopause symptoms**	
Abdominal pain		Hot flashes	
Nausea		Night sweats	
Vomiting		Difficulty sleeping	
Constipation		Decreased libido	
Diarrhea		Mood changes	
Blood in stool		Brain fog	
Change in bowel habits			
		Psychological	
Genitourinary		Anxiety	
Painful urination		Depression	
Leaking urine		Difficulty sleeping	
Urinary urgency		Panic attacks	
Urinary frequency			
Blood in urine		**Other:**	
Nocturia (urinating 2 or more times/night)			

Please list any other concerns you would like to discuss today: _____

_____

_____

(Continued on back)

CURRENT MEDICATIONS (prescription, over the counter, vitamins, birth control, herbs etc)

Name	Dosage (mg)	Frequency	Date Started	Prescribing MD

ALLERGIES (drugs, foods, latex) REACTION

Any changes in your period: _____

Do you have sex? ☐ Yes ☐ No

If yes, do you have sex with: ☐Men ☐ Women ☐Both

Have you had a new sexual partner since your last exam? : ☐Yes ☐No

How do you prevent pregnancy? _____

Medical/Surgical History updates since last visit:_____

_____

_____

Social History updates since last visit (marital status, job, school, family, stressors etc):_____

_____

_____

Abuse Screen ☐None ☐Physical abuse ☐Sexual abuse ☐Emotional abuse

Tobacco/Cigarettes Use: ☐Never ☐Quit (date)_____ ☐ Current, ____packs/day, X ____yrs

Alcohol Use: ☐No ☐Yes, # _____ drinks per week (☐beer ☐wine ☐liquor)

Is alcohol use a concern for you or others? ☐No ☐Yes

Drug Use: ☐No ☐Yes, If so, what drug(s)_____

Exercise: Do you exercise regularly? ☐No ☐ Yes

If no, why not? _____

If yes, what kind of exercise_____

How often? _____How long? _____

Diet: How do you rate your current diet? ☐ Good ☐ Fair ☐ Poor