

CHECKUP QUESTIONS

Please answer all questions. If a question does not apply, place N/A on that line.

Name _____ Date: _____

FOR WHAT REASON ARE YOU BEING SEEN TODAY? PLEASE LIST ANY SPECIFIC PROBLEMS OR SYMPTOMS THAT ARE BOTHERING YOU.

What was the date of your last menstrual period? _____

How many days does your period last? _____

Has the flow changed in any way? (Do you have clotting?) _____

What method of birth control are you using? _____

What medications including over the counter medications and vitamins are you taking?

Please list any allergies or drug sensitivities: _____

Who is your primary care physician? _____

Has he performed any laboratory tests? _____

Have you had any major illnesses or surgery since your last visit?

Are you experiencing any of the following symptoms?

Vaginal discharge Yes No

Vaginal itching/burning? Yes No

Problems with your period – cramping Yes No

Hot flashes Yes No

Urinary symptoms Yes No

Do you lose urine when you cough or sneeze? Yes No

Do you smoke cigarettes? Yes No

If YES, how many per day? _____

Do you drink alcoholic beverages? Yes No

If YES, how many per week? _____

Do you exercise? Yes No

If YES, what type and how often? _____

Northlake OBGYN

5635 Peachtree Pkwy., Suite 140, Norcross, GA 30092

Phone: (770) 939-5102 Fax: (770) 938-9323