Patient's Name:_______________________________________ DOB:______________

In an effort to provide the best experience during your office visit today and help us keep current on your health, please take a few minutes to complete the following questions.

MEDICATIONS YOU ARE TAKING

Name of Medication	Dosage	Prescribing Doctor

CONTRACEPTION N/A☐

What is your current form of birth control?________ Circle: condoms, vasectomy,BTL/Essure, IUD Pills, patch, Nuvaring, natural family planning

When are you planning to have another child (please check one)

___Within the next year ___Within the next 5 years
___Within the next 10 years ___I am done having children

MENSTRUAL PERIODS N/A☐

When was your last period? ____________________

What is the frequency of your periods? _____________days Length? ___________days

Do you ever feel as though your periods impact the quality of your life? ___Yes ___No

Do you ever experience irregular or inconsistent bleeding patterns? ___Yes ___No

URINARY HEALTH N/A☐

Do you ever leak urine when you cough, laugh or sneeze? ___Yes ___No

Do you ever feel as though you have to urinate urgently? ___Yes ___No

Do you feel like you have to urinate frequently? ___Yes ___No

Do you ever experience painful urination? ___Yes ___No

VACCINES

Zostivax (shingles)	Circle: yes/ no	I do not know ___	(if you are 50 or over)
Last tetanus	Year ___	I do not know ___	
Gardasil (all 3 doses?)	Circle: yes/ no	I do not know ___	
Twinrix (Hep A&B) all 3 doses?	Circle: yes/ no	I do not know ___	

Are there any concerns/issues that you would like to discuss today?_______________

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