



**INTERVAL HISTORY**

D.O.B.:

Name

Addressograph

**I Social History** (please check if applicable):

Single       Married       Living Together  
 Widowed       Separated       Divorced  
 Civil Union       Lesbian       Bi-sexual

Please check (✓)      Yes      No

Tobacco Use .....  
# of cigarettes \_\_\_\_ / day, for \_\_\_\_ years

Alcohol .....  
# of glasses \_\_\_\_ / week

Recreational Drugs .....

Domestic Violence .....

Health Hazard at Home/Work .....

Occupation \_\_\_\_\_

Seat Belt Use .....

Balanced Diet .....

Folic Acid Intake .....

Calcium Intake .....

Regular Exercise .....

Caffeine Intake .....

Breast Self-Exam Monthly .....

Vitamins/Herbs or Supplements .....

List: \_\_\_\_\_

Cultural/Religious Restrictions .....

Medications .....

List: \_\_\_\_\_

Allergies .....

List: \_\_\_\_\_

**III Birth Control** (please check the method(s) which you use, if any):

Condom       Withdrawal       Tubal Ligation  
 Diaphragm/Cervical Cap       Foam or Jelly  
 Birth Control Pill       Birth Control Patch  
 Lunelle       Depo-Provera Injection  
 Vasectomy       IUD  
 No Intercourse       Contraceptive Ring  
 Rhythm/Natural Family Planning  
 Please check here if you would like to change method

**IV Menses**

Date of last menstrual period .....

From the first day of my period to first day of my next period, my menses occur every \_\_\_\_ days, and last for \_\_\_\_ days.

Do you **currently** have any of the following menstrual problems?

Please check (✓)      Yes      No

Painful periods.....

Irregular periods or bleeding .....

Spotting or bleeding between menses.....

Bleeding after intercourse.....

Pain with intercourse .....

Pre-menstrual syndrome (PMS).....

**V Gynecological** # of pregnancies \_\_\_\_ # of births \_\_\_\_

Do you **currently** have any of the following?

Please check (✓)      Yes      No

Vaginal discharge or odor.....

Vulvar itching or irritation.....

Pelvic pain .....

Hot flashes .....

Bulging from vagina.....

Uncontrollable loss of urine .....

Concerns about sexually transmitted diseases (STD's) .....

Have you had any new partners since your last visit .....

Are you currently in a relationship .....

Change in interest in sexual activity .....

How long have you been together .....

Are you trying to conceive .....

How many months .....

I will be planning a pregnancy; when .....

**II General Health**

Please check (✓)      Yes      No

Do you **currently** have any of the following:

Swollen or enlarged glands in the neck, underarm or groin area.....

Breast problem or discharge.....

Change in bowel habit .....

Pain, burning or frequent urination.....

Feelings of depression .....

Thoughts of hurting yourself .....

Is alcohol a problem for yourself or a family member .....

Have you ever been sexually abused .....

Are you in a relationship in which you feel mentally/physically abused .....

**VI Other**

Since your last visit to this office, have you or a family member had any operations, hospitalizations, serious illnesses or mental health care? Please explain:

\_\_\_\_\_

\_\_\_\_\_

Is there any other information or problems I need to know that was not asked on this questionnaire? Explain below.

\_\_\_\_\_

\_\_\_\_\_

My cholesterol level is.....

It was last checked.....

Yes      No

**Are your immunizations up-to-date?**

Rubella.....

Tetanus .....

Hepatitis B .....

FORM NO. XXXXX (10/02)

Patient  
Signature

Provider  
Signature

Date