THE WOMEN'S GROUP OF GWINNETT, P.C.
CHECKUP QUESTIONS

Please answer all questions, if a question does not apply, place NA 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____
Vaginal itching/burning?_____ Problems with your period – cramping_____
hot flashes_____ Urinary symptoms_____

Do you lose urine when you cough or sneeze?_____

Do you smoke cigarettes?_____ How many per day?_____

Do you drink alcoholic beverages? _____ How many per week?_____

Do you exercise?_____ What type and how often?_____