

**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? _____