Jennifer S. Hayes DO, FACOOG
Sharon Welsh, MSN, ARNP

INTERVAL HISTORY

Thank you for taking the time to fill out the following questions. We use this information to update your medical records.

PLEASE PRINT Today's Date: ___________

Last Name: ________________________ First Name: ____________________ MI: _____

When was your last Menstrual Period: ______________________

Type of Contraceptive: ______________________________________

Who is your Primary Care Physician? ____________________ Referring Physician, if any ________________

Since your last visit to our office, have you had any significant gynecological problems? (please list)

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____

Since your last visit to our office, have you had any serious illnesses or major surgeries? (please list)

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____

Please list all the medications your are currently taking. Include over the counter medications, herbs, vitamins, diet pills.
• ***Please include hormone replacement and dosage.***

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

Do yo have any **SIGNIFICANT** problems with the following?

	Yes	No		Yes	No
Weight loss/gain			Nausea/Vomiting		
Fever			Diarrhea		
Fatigue			Bloody stool		
Headaches			Constipation		
Muscle weakness			Abdominal or pelvic pain		
Vision changes			Gas		
Hot flashes/Night sweats			Blood in urine		
Mouth sores			Pain with urination		
Sinusitis			Urgency/Frequency urination		
Ringing in ears			Leakage of urine		
Chest pain			Skin rashes		
Palpitations			Skin ulcers		
Shortness of breath			Easy bruising		
Wheezing/Cough			Swollen glands		
Leg swelling			Blackouts		
Trouble walking			Dizziness		
Depression/Crying			Numbness/Tingling		
Breast pain / Lump/ or Nipple discharge			Sexual problems		
Hair loss			Heavy Periods / PMS		

Signature: ______________________ Physician signature: ______________________