INTERVAL HISTORY

Name:____**Age:**________________**Date:**________________

What is the reason for this visit?____

Are you experiencing any burning/discomfort upon urination?___________________________________

Are your periods regular?_______**Last Cycle?**__________ **How long did it last?**_____________________

If period irregular, please explain:____

Birth control name or method:_____________________**Tubal?**___________________________________

Are you satisfied?________________________________

Are you currently sexually active?________ **Would you like STD screening?**_______________________

Are you a smoker?__________________ **If you have stopped recently then when:**_________________

Is there a history of the following cancers on either side of your family since your last visit?

Breast Cancer______________________ Ovarian Cancer___________________________

Colon Cancer_______________________ Endometrial Cancer_______________________

Please state if any of these tests have been performed and dates if remembered since your last visit:

Cholesterol__________Mammogram_______________Colonoscopy________________

Bone Density________________Thyroid_____________Blood Sugar_________________

Urinalysis___________________

Most recent dates of the following vaccines since your last visit:

Flu___________Shingles_____________Tdap_________Pneumococcal_______________

Covid19_____________

Please list any new medications that are not on the Summary Sheet including any OTC:

____

Please mark out any medications that are on the Summary Sheet that have been discontinued.

Office Use Only: Weight______________Height_______________BP___________Pulse_________