



THE EMORY CLINIC, INC.

PATIENT INTERVAL HISTORY

EMORY WOMEN'S CARE

Please answer each of the following questions by checking the appropriate box.

Since your last visit...

	YES	NO
Have you been diagnosed with any new medical problems?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any operations?	<input type="checkbox"/>	<input type="checkbox"/>
Have you developed any new allergies?	<input type="checkbox"/>	<input type="checkbox"/>
Have you experienced a change in your menstrual period?	<input type="checkbox"/>	<input type="checkbox"/>
Have you missed any periods?	<input type="checkbox"/>	<input type="checkbox"/>
Do you think you might be pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
Have you changed methods of birth control?	<input type="checkbox"/>	<input type="checkbox"/>
Are you having any vaginal discharge, itching or odor?	<input type="checkbox"/>	<input type="checkbox"/>
Are you having any pain during intercourse?	<input type="checkbox"/>	<input type="checkbox"/>
Are you having any abdominal or pelvic pain?	<input type="checkbox"/>	<input type="checkbox"/>
Are you having any problems with urination?	<input type="checkbox"/>	<input type="checkbox"/>
Are you having any problems with your bowels?	<input type="checkbox"/>	<input type="checkbox"/>
Are you concerned about sexually transmitted diseases?	<input type="checkbox"/>	<input type="checkbox"/>
Have you noticed any change in you breasts?	<input type="checkbox"/>	<input type="checkbox"/>
Have you developed any breast lumps?	<input type="checkbox"/>	<input type="checkbox"/>
Have you developed any breast discharge?	<input type="checkbox"/>	<input type="checkbox"/>
Do you smoke? If yes: how much? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you drink alcohol? If yes: how much? _____	<input type="checkbox"/>	<input type="checkbox"/>
Have there been any changes in the health of your close family?	<input type="checkbox"/>	<input type="checkbox"/>

Please list any nonprescription medications or illicit drugs:

Please list any prescription medications

Please describe the reason for your visit today:

