Division of **Pediatric, Adolescent, & Young Adults** Gynecology
Follow-Up Visit Patient History Intake Form

Date: _____ Patient Name: _____ DOB: _____ Age: _____

Gender Identity: ☐ Female ☐ Male ☐ Nonbinary ☐ Other: _____
Sex assigned at birth: ☐ Female ☐ Male
Preferred pronouns: ☐ She/Her ☐ He/Him ☐ They/them ☐ Other: _____

Primary Care Provider:_____

*_Patient_ phone number: _____Can we leave a message? ☐ Yes ☐ No

Guardian phone _____ Relationship_____

Reason for Today's Visit

Last menstrual period: **Date:_____ or ☐ N/A** My period comes every ___-___ days and lasts___-___ days, I usually change my pad/tampon every ___ hours on the heaviest day of my period.
Current birth control / menstrual regulation: _____or ☐ NONE / NA Have you ever had sex? ☐ Yes ☐ No Have you ever been pregnant? ☐ Yes ☐ No **Are you currently sexually active?** ☐ Yes ☐ No **If yes, date of last intercourse:_____** Current partners: ☐male ☐female ☐both ☐other New partner in last 12 months? ☐ Yes ☐ No
Have you received the HPV vaccine? ☐ Yes ☐ No If yes, shots received: (choose one) ☐ 1 ☐ 2 ☐ 3
Current Medications: **Any new medical conditions since last visit:**
Allergic to any medications?: ☐ No ☐ Yes **:**

REVIEW OF SYSTEMS:

Please select any of the following symptoms you are having today.

☐ I have **NONE** of the below symptoms

☐ Constitutional: weight loss or gain, changes in appetite or eating habits, fever or fatigue

☐ **GI: nausea/vomiting, diarrhea, constipation, abdominal pain or rectal bleeding**

☐ Urinary: painful urination, urinary urgency ('got to go') or loss of urine

☐ **GYN: irregular or heavy menstrual bleeding, painful periods, vaginal discharge, vulvar itching or irritation, painful intercourse**

☐ Psychiatric: anxiety or depression, thoughts of hurting myself or others

Where do you want your prescriptions to go today?
Pharmacy Name/Number_____