WENDOVER OB-GYN & INFERTILITY, INC.

Established GYN Form

Patient Name: _____ **Age**: _____

Today's Date: _____ **Chart #**: _____

In the lines below, please tell us why you are here today. If you have any special problems or symptoms you would like to discuss with the doctor today, please include below:

_____

_____

Any ***new*** medical problems? ❑ Yes ❑ No If yes, please explain: _____

_____

Any ***new*** hospitalizations or surgeries? ❑ Yes ❑ No If yes, please explain: _____

_____

Date of last menstrual period:_____

List all current medications and dosages and why you are taking them (include vitamins and supplements):_____

_____

Preferred Pharmacy:_____*Location*: _____

Preferred Mail Order Pharmacy: (provide address, phone, and fax numbers):

_____

_____

Have any family members had ***new*** medical problems (cancer, heart attack, diabetes, etc.)?

❑ Yes ❑ No If yes, please explain: _____

_____

Do you have any food or drug allergies? ❑ Yes ❑ No If yes, please list: _____

_____

Are you allergic to latex? ❑ Yes ❑ No