Northwell Health℠ **Contemporary Women's Care**

Short-Term Follow-Up Visit

Date: _____

Name: _____

Date of Birth: ____/____/_____ Age: _____

Please check your primary contact:

☐ Home: _____

☐ Work: _____

☐ Mobile: _____

☐ Email: _____

REASON FOR FOLLOW UP:

_____

_____

First day of your last menstrual period: ____/ ____/ ____

How old were you when you had your first period? _____

Do you use contraception? ☐ Yes ☐ No

If yes, please specify which type of contraception(s) used below:

☐ Condoms ☐ Diaphragm ☐ Essure

☐ Oral Contraception ☐ Tubes tied ☐ Depo provera shot

☐ IUD ☐ Vasectomy ☐ Natural family planning

Do you smoke cigarettes? ☐ Yes ☐ No

Do you have any personal or family history of blood clotting disorders?

☐ Yes ☐ No

For office use only:

Ht: _____ Wt: _____

BP: _____ Temp: _____

Pap: _____

Mammo: _____

Breast U/S: _____

Pelvic U/S: _____

BD: _____

CURRENT MEDICATIONS

Please list all medications you are currently on and their dosage (including any over-the-counter and complementary therapies)

Medication	**Dose Taken**
_____	_____
_____	_____
_____	_____

Please let us know if there have been any changes in the following information:

Any new medical conditions? ☐ Yes ☐ No

If yes, please specify: _____

Any new surgeries? ☐ Yes ☐ No

If yes, please list (including dates): _____

Any new allergies? ☐ Yes ☐ No

If yes, please specify and list reaction: _____

PLEASE CONTINUE TO 2ND PAGE

Name: _____ Date of Birth: ____/_____/_____

PLEASE CHECK ALL THAT CURRENTLY APPLY TO YOU:

Systemic Symptoms
- ☐ Recent change in weight
- ☐ Chills
- ☐ Fever
- ☐ General poor feeling overall
- ☐ None
- ☐ Other: _____

Eye Symptoms
- ☐ Vision problems
- ☐ None
- ☐ Other _____

Ear, Nose and Throat Symptoms
- ☐ Please list any: _____
- ☐ None

Breast Symptoms
- ☐ Breast pain
- ☐ Nipple discharge
- ☐ Breast lump
- ☐ None
- ☐ Other: _____

Cardiovascular Symptoms
- ☐ Chest pain or discomfort
- ☐ Fast heart rate
- ☐ Heart palpitations
- ☐ None
- ☐ Other: _____

Musculoskeletal Symptoms
- ☐ Neck pain
- ☐ None
- ☐ Other: _____

Pulmonary Symptoms
- ☐ Please list any: _____

_____
- ☐ None

Gastrointestinal Symptoms
- ☐ Appetite
- ☐ Nausea/ Vomiting
- ☐ Abdominal pain
- ☐ Diarrhea
- ☐ None
- ☐ Other: _____

Endocrine Symptoms
- ☐ Excessive sweating
- ☐ Excessive thirst
- ☐ None
- ☐ Other _____

Neurological Symptoms
- ☐ Dizziness
- ☐ Vertigo
- ☐ Fainting
- ☐ Headaches
- ☐ Motor disturbances
- ☐ Sensory disturbances
- ☐ None
- ☐ Other: _____

Psychological Symptoms
- ☐ Sleep disturbances
- ☐ Anxiety
- ☐ Depression
- ☐ Decrease in sexual interest
- ☐ None
- ☐ Other: _____

Skin Symptoms
- ☐ Excessive itching
- ☐ Skin lesions
- ☐ Rashes
- ☐ None
- ☐ Other: _____

Please list any other symptoms you would like us to be aware of: _____

_____

Do you have any interest in the following Laser and Facial Services?

☐ Hair Removal ☐ Vein Therapy ☐ Skin Tightening ☐ Photo Genesis ☐ Microdermabrasion ☐ Chemical Peels

Please return all forms to the front desk when finished. You will be called in shortly.