Christy Walker, MD
GYNECOLOGY • COSMETIC SURGERY

ESTABLISHED PATIENT FORM

Name: _____ Date: _____

Primary Care Physicians (PCP) _____ Phone#_____

1. Interval History, major health events, operations, hospitalizations and current problems since we last saw you.

_____
_____
_____
_____
_____

2. Allergies: List the name of drugs (including intravenous dye/contrast and list the type of reason (hives, rash, or swelling, etc.)

_____
_____

3. Latex Allergy? Yes _____ No _____
4. List All of your current medications, their dosage and frequency. Include over-the counter medications, vitamins, minerals, supplements or herbal medications.

_____
_____
_____

5. Height_____ Recent Weight_____ Weight gain since last visit_____
   Last Menstrual Period: _____
   Recent irregular bleeding, abnormal vaginal discharge, blood in stool or black tarry stool? Yes_____ No _____

   Please explain:
   _____
   _____

Patient Signature_____ Date_____

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