

Account #: _____

Today's Date: _____ Age: _____

Name: _____ Pref. Name: _____



Reason for Today's Visit: Annual Follow-Up Problem Visit Post-Op Postpartum

Since Your Last Visit:

Health Issues: _____

Gynecological Issues: _____

Bladder Issues: _____

Gynecological History:

Last Menstruation Period: _____ Last Annual Exam: _____

Last Pap Smear: _____ Ever had an abnormal pap smear? **Y N**

If yes, what treatment did you receive?: _____

Do you have heavy, bothersome menstruation periods? **Y N**

of Pregnancies: _____ # of Live Births: _____ # of Vaginal Births: _____ # of C-Sections: _____

Age at First Child: _____ Age at First Period: _____ If Menopausal, Age at Last Period: _____

Patient History:

Drug Allergies: _____

Current Medications: _____

Operations: _____

Last Mammogram (over 40): _____ Do you do self breast exams? **Y N**

Last Colonoscopy (over 50): _____

Ever had a Bone Density Scan? **Y N** When: _____ Ever had a Thyroid Test? **Y N** When: _____

Last Cholesterol Screening: _____ Have you had the HPV vaccine (cervical cancer vaccine)? **Y N**

Do you smoke? **Y N** Do you drink? **Y N** Do you do recreational drugs? **Y N** Kind: _____

Are you currently sexually active? **Y N** Have you ever been sexually active? **Y N**

If you use birth control, what type?: _____

Family History:

Type of cancer, and relationship to you: _____

Diabetes, and relationship to you: _____

Blood clots, and relationship to you: _____

Birth defects or mental retardation?: _____

Other medical problems?: _____



If all above information is still accurate please sign _____ Date _____

Review of Symptoms

Patient Name: _____ Date: _____

****Please answer Y or N to the following ****

General Health

| | | |
|---|---|---------------------------|
| Y | N | Appetite Loss |
| Y | N | Fever |
| Y | N | High Blood Pressure |
| Y | N | Recent Weight Gain/ Loss |
| Y | N | Unusual Weakness/ Fatigue |

Other:

Head / Neck

| | | |
|---|---|-------------------------|
| Y | N | Hearing Loss |
| Y | N | Nose Bleeds |
| Y | N | Runny Nose |
| Y | N | Sore Throat/ Hoarseness |
| Y | N | Throat Swelling |

Other:

Cardiovascular

| | | |
|---|---|-------------------------------------|
| Y | N | Leg Swelling |
| Y | N | Palpitations |
| Y | N | Shortness of Breath When Lying Flat |
| Y | N | Slow/ Rapid Heart Beat |

Other:

Respiratory

| | | |
|---|---|------------------------------------|
| Y | N | Chest Pain/ Breathing |
| Y | N | Coughing or Wheezing |
| Y | N | Difficulty Breathing with Activity |
| Y | N | Shortness of Breath |

Other:

Muscles / Joints

| | | |
|---|---|-------------------|
| Y | N | Pain or Stiffness |
|---|---|-------------------|

Other:

Genitourinary

| | | |
|---|---|--|
| Y | N | Abnormal Pap Smears |
| Y | N | Bleeding between periods, after menopause or irregular periods |
| Y | N | Heavy Vaginal Bleeding/ Painful Bleeding |
| Y | N | Painful Intercourse |
| Y | N | Painful or Frequent Urination |
| Y | N | Sexually Transmitted Diseases |
| Y | N | Vaginal Discharge |

Other:

Breast / Skin

| | | |
|---|---|------------------------------------|
| Y | N | Abrasions or Lacerations |
| Y | N | Do you perform monthly self exams? |
| Y | N | Lumps, Masses or Discharge |
| Y | N | Rash, Bruising or Swelling |

Other:

Hematology

| | | |
|---|---|----------------------------------|
| Y | N | Anemia/ Blood Transfusion |
| Y | N | Easy Bruising/ Abnormal Bleeding |
| Y | N | Swollen Lymph Nodes |

Other:

Gastrointestinal

| | | |
|---|---|-------------------------------------|
| Y | N | Blood in Stool or Black Tarry Stool |
| Y | N | Constipation or Diarrhea |
| Y | N | Nausea or Vomiting |
| Y | N | Pain or Bloating |

Other: