

Name: _____ Age: _____ DOB: _____ Today's Date: _____

Any concerns you would like to discuss during your visit:

Gynecological History			Personal History	
Last menstrual period	Age periods began	Length of cycle	Primary care physician:	
Currently Sexually Active?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Male <input type="radio"/> Female Partner	Place of Employment:	
Menopausal:	<input type="radio"/> Yes <input type="radio"/> No	Since Age:	Job Title	
Current method of Contraception?			I live with:	
If you are using OC's, for how long?			<input type="radio"/> Married <input type="radio"/> Single <input type="radio"/> Divorced <input type="radio"/> Widow <input type="radio"/> Other _____	
Last Pap Smear? Date: _____ Result: _____			Do you exercise? <input type="radio"/> Yes <input type="radio"/> No Describe: _____	
Date of Last:	Mammogram:	Colonoscopy:	Do you smoke? <input type="radio"/> Yes <input type="radio"/> No How much? _____	

OBGYN History Have you ever had any of the following?	Personal History																
<table style="width:100%;"> <tr> <td><input type="checkbox"/> Abnormal/irregular vaginal bleeding</td> <td><input type="checkbox"/> Uterine fibroids/polyps</td> </tr> <tr> <td><input type="checkbox"/> Abnormal pap smear</td> <td><input type="checkbox"/> Hysterectomy/salpingo-oophorectomy</td> </tr> <tr> <td><input type="checkbox"/> Colposcopy/cryo/laser surgery</td> <td><input type="checkbox"/> Urinary incontinence</td> </tr> <tr> <td><input type="checkbox"/> Condyloma (genital warts)</td> <td><input type="checkbox"/> Breast disease/surgery</td> </tr> <tr> <td><input type="checkbox"/> Gonorrhea or Chlamydia (circle)</td> <td><input type="checkbox"/> Infertility</td> </tr> <tr> <td><input type="checkbox"/> Herpes</td> <td><input type="checkbox"/> DES exposure</td> </tr> <tr> <td><input type="checkbox"/> Pelvic Inflammatory Disease (PID)</td> <td><input type="checkbox"/> Ovarian cysts</td> </tr> <tr> <td><input type="checkbox"/> Endometriosis</td> <td><input type="checkbox"/> Ovarian /uterine/cervical cancer</td> </tr> </table>	<input type="checkbox"/> Abnormal/irregular vaginal bleeding	<input type="checkbox"/> Uterine fibroids/polyps	<input type="checkbox"/> Abnormal pap smear	<input type="checkbox"/> Hysterectomy/salpingo-oophorectomy	<input type="checkbox"/> Colposcopy/cryo/laser surgery	<input type="checkbox"/> Urinary incontinence	<input type="checkbox"/> Condyloma (genital warts)	<input type="checkbox"/> Breast disease/surgery	<input type="checkbox"/> Gonorrhea or Chlamydia (circle)	<input type="checkbox"/> Infertility	<input type="checkbox"/> Herpes	<input type="checkbox"/> DES exposure	<input type="checkbox"/> Pelvic Inflammatory Disease (PID)	<input type="checkbox"/> Ovarian cysts	<input type="checkbox"/> Endometriosis	<input type="checkbox"/> Ovarian /uterine/cervical cancer	Have you ever smoked? <input type="radio"/> Yes <input type="radio"/> No When and how much? _____ Caffeine beverages: <input type="radio"/> Yes <input type="radio"/> No # Cups a Day _____ Do you drink alcohol? <input type="radio"/> Yes <input type="radio"/> No How much? _____ Any history of drug abuse? <input type="radio"/> Yes <input type="radio"/> No Describe: _____ Any history of sexual abuse? <input type="radio"/> Yes <input type="radio"/> No Describe: _____ Have you ever been tested for HIV? <input type="radio"/> Yes <input type="radio"/> No Would you like to be tested for HIV? <input type="radio"/> Yes <input type="radio"/> No Date and results of last test _____ Ever experienced a violent relationship <input type="radio"/> Yes <input type="radio"/> No
<input type="checkbox"/> Abnormal/irregular vaginal bleeding	<input type="checkbox"/> Uterine fibroids/polyps																
<input type="checkbox"/> Abnormal pap smear	<input type="checkbox"/> Hysterectomy/salpingo-oophorectomy																
<input type="checkbox"/> Colposcopy/cryo/laser surgery	<input type="checkbox"/> Urinary incontinence																
<input type="checkbox"/> Condyloma (genital warts)	<input type="checkbox"/> Breast disease/surgery																
<input type="checkbox"/> Gonorrhea or Chlamydia (circle)	<input type="checkbox"/> Infertility																
<input type="checkbox"/> Herpes	<input type="checkbox"/> DES exposure																
<input type="checkbox"/> Pelvic Inflammatory Disease (PID)	<input type="checkbox"/> Ovarian cysts																
<input type="checkbox"/> Endometriosis	<input type="checkbox"/> Ovarian /uterine/cervical cancer																

Physician Notes:

Pregnancy history

Number of times pregnant:	# of Abortions:	# of Miscarriages:	# of Children:
Delivery Year	Type of Delivery (Vaginal or C-Section)	Baby's Birth Weight	Pregnancy/Delivery Complications

Any changes in your medical history since your last annual exam?

Any changes in your FAMILY medical history since your last annual exam?

Please list all medications you are taking	Allergies including drug allergies and reaction

Have you had any of the following immunizations? Rubella Hepatitis B Pneumovax Tetanus Influenza

Name:		Age:	G	P	Date:	
HT:	WT:	BMI:	BP:	Temp:	Pulse:	Respirations:
LMP	BCM	Last Pap Results		Last Mammogram	Last Colonoscopy:	Last DexaScan:
ALLERGIES						
MEDICATIONS						
History of Present Illness						
EXAM						
General Appearance:		Well developed	Well nourished	Normal mood/affect	Oriented x 3	No acute distress
Neck		Supple	Without masses	Without thyromegaly		
Breast		No dominant masses	No skin changes	No nipple discharge		
Lungs		Clear to auscultation bilaterally		Normal respiratory effort		
Heart		Regular rhythm and rate		No murmurs/gallops		
Abdomen		Soft, non-distended	No masses/HSM	No Hernias		
Back		No CVA tenderness				
Skin		No lesions		No abnormal moles		
Lymphatic		No neck	No axillare	No groin lymphadenopathy		
Extremities		Without varicosities	Without edema	Nontender calves		
Pelvic Exam		Normal external genitalia				
Urethral meatus/urethra		Without lesions, tenderness or prolapse				
Bladder		Without masses, tenderness		Well supported		
Vagina		Well supported	No lesions	No abnormal discharge		
Cervix		Without lesions		No CMT		
Uterus	Position:	Normal size & shape	Nontender	Without descent		
Adnexa		Normal size	No adnexal masses	No tenderness		
Anus/Perineum		No lesions				
Rectal:		Normal sphincter tone	No hemorrhoids	No tenderness		
Other findings:						

