PATIENT NAME:_____ **DATE:** _____

Phone #: Home_____ Cell_____ Work _____

Local Pharmacy (name & address)_____

Mail Away Pharmacy (phone & address)_____

FOR OFFICE USE ONLY

AF Y N NA

Reviewed by_____

GYNECOLOGIC HISTORY UPDATE

SINCE YOUR LAST COMPREHENSIVE EXAM IN THIS OFFICE, HAVE YOU:

1. Had any surgery, major or minor? NO YES Explain:
2. Had any hospital admissions? NO YES Explain:
3. Had any new medical diagnosis? NO YES Explain:
4. Had any changes in family medical history? NO YES Explain:
5. How long does your monthly period last? _____ days
    a. avg # of days from beginning of one period to beginning of next _____
    b. Do you have pain with your periods? NO YES
    c. Do you ever feel as though your periods impact the quality of your life? NO YES
    d. Do you ever experience irregular or inconsistent bleeding patterns? NO YES
6. Please list all current prescriptions AND non-prescription medications including dosages:

    1. 4.
    2. 5.
    3. 6.

    Have you developed any medication allergies? NO YES Explain:

7. Within the last year, have you been hit, slapped, kicked or otherwise physically hurt by someone? NO YES

    Are you in a relationship with a person who threatens or physically hurts you? NO YES

    Has anyone forced you to have sexual activities that make you uncomfortable? NO YES
8. Had any bladder problems? NO YES Explain:
9. Exercise Type: Frequency:
10. Have you had the Gardisil vaccination? NO YES If yes, when?
11. Do you do breast self exams (BSE)? NO YES How often?
12. Cigarette smoking status: Never ( ) Former ( ) year quit _____ Current ( ) #years ____ Packs per day_____

PLEASE INDICATE ANYTHING YOU WOULD LIKE TO DISCUSS THIS OR FUTURE VISIT:

FAMILY MD: _____ Patient signature_____

PATIENT NAME:_____ DATE: _____ DOB:_____

AGE _____ LMP_____ WEIGHT _____ BP_____HgB_____ Urine_____

CC: **ROS:**

Thyroid NL ( ) ABNL ( )

Breast Left & Right ( )

Supine & Upright ( )

Masses No ( ) Yes ( )

Tenderness No ( ) Yes ( )

Discharge No ( ) Yes ( )

Skin changes No ( ) Yes ( )

Lymph nodes No ( ) Yes ( )

Abdomen NL ( ) ABNL ( )

Pelvic BUS/Vulva

Vagina

Uterus

Adnexae

Rectal Deferred ( ) NL ( ) ABNL ( )

Guaiac Negative ( ) Positive ( )

ASSESSMENT:

FTFT

Last mammo:_____

Chaperone:

_____deferred at pt request

_____ present _____

PLAN:

( ) Refer to _____

( ) BRCA Assessment

( ) Pap

( ) TBSE

( ) Calcium (mg/day)/vitamin D

( ) Colonoscopy due _____

( ) Exercise min 5x per week

( ) Mammo _____

( ) RTO 1 year AV

( ) DEXA _____

( ) Lipids (FMD)

( ) BC/HRT _____