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: