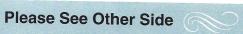
| STAFF USE | | | | Obstetrical | | | |
|--|---|--|------------------------|---------------------------------|--|--|--|
| Account #: | | | (Fart | & Gynecological Group, P.C.® | | | |
| Today's Date: | | | | Group, P.C. | | | |
| Name: Pref. Name: | | | | | | | |
| Reason for Today's Visit: | New Patient Annual F | ollow-Up Problem Vis | sit Post-Op | Postpartum | | | |
| | | Your Last Visit: | 1 озт-ор | r Ostpartum | | | |
| Chronic Health Issues e.g. Di | abetes, Thyroid, Blood Pressure: | | | | | | |
| | | | | | | | |
| GYN, Bladder or Pelvic Issues | s: | | | | | | |
| | | ological History: | | | | | |
| | struation Period: Last Annual Exam: | | | | | | |
| Last Pap Smear: | Pap Smear: Ever had an abnormal pap smear? YN | | | | | | |
| If yes, what treatment did you | receive?: | | | | | | |
| Do you have heavy, bothersor | me menstruation periods? Y N | I | | | | | |
| # of Pregnancies: | # of Live Births: # of \ | /aginal Births: # o | of C-Sections: | | | | |
| | Age at First Period: If | | | | | | |
| | Pat | ient History: | | | | | |
| Drug Allergies: | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| Last Mammogram (over 40): | | Do you do self breast | exams? Y N | | | | |
| | | | | | | | |
| | ? Y N When: | | | | | | |
| Last Cholesterol Screening: | На | ve you had the HPV vaccir | ne (cervical cancer va | accine)? Y N | | | |
| | ou drink? V M Davisie | ecreational drugs? Y N | Kind: | | | | |
| Do you smoke? Y N Do y | od dillik: r in Do you do re | 3 | | | | | |
| Are you currently sexually activ | re? Y N Have you ever bee | n sexually active? Y N | | | | | |
| Are you currently sexually activ | re? Y N Have you ever beel JD, Birth Control Pills, Implant, D | n sexually active? Y N | | omy, Hysterectomy | | | |
| Are you currently sexually activ | re? Y N Have you ever been JD, Birth Control Pills, Implant, Do Fam | n sexually active? Y N epo, Rhythm Method, Cond illy History: | doms, Foam, Vasect | | | | |
| Are you currently sexually activ Current Birth Control (circle): IL History of Breast, Colon, Ovaria | re? Y N Have you ever been JD, Birth Control Pills, Implant, De Fam an Cancer, and relationship to you | n sexually active? Y N epo, Rhythm Method, Cond illy History: u: | doms, Foam, Vasect | | | | |
| Are you currently sexually activ Current Birth Control (circle): IL History of Breast, Colon, Ovaria | re? Y N Have you ever been JD, Birth Control Pills, Implant, De Fam an Cancer, and relationship to you | n sexually active? Y N epo, Rhythm Method, Cond illy History: u: | doms, Foam, Vasect | | | | |
| Are you currently sexually active Current Birth Control (circle): IL History of Breast, Colon, Ovarian Bleeding or Clotting Disorders, | re? Y N Have you ever been JD, Birth Control Pills, Implant, Do Fam | n sexually active? Y N epo, Rhythm Method, Cond illy History: u: | doms, Foam, Vasect | | | | |







Review of Symptoms

| Patient Name: _ | | Date: | | | | | |
|-----------------|----|--|--------|----|--|--|--|
| | | Since your last visit have you experienced **Please answer Y or N to the following** | | | | | |
| | | General Health | | | Genitourinary | | |
| Υ | N | Appetite Loss | Υ | Ν | Abnormal Pap Smears | | |
| Υ | N | Fever | Y | N | Bleeding between periods, after menopause or irregular periods | | |
| Υ | N | High Blood Pressure | Y | NI | N Heavy Vaginal Bleeding/ Painful Bleeding | | |
| Υ | N | Recent Weight Gain/ Loss | , T | | | | |
| Υ | N | Unusual Weakness/ Fatigue | Υ | N | Painful Intercourse | | |
| Other: | | | Υ | N | Painful or Frequent Urination | | |
| * | | Head / Neck | Υ | N | Sexually Transmitted Diseases | | |
| Υ | Ν | Hearing Loss | Υ | N | Vaginal Discharge | | |
| Υ | N | Nose Bleeds | Other: | | | | |
| Y | N | Runny Nose | | | Breast / Skin | | |
| Y | N | Sore Throat/ Hoarseness | Υ | N | Abrasions or Lacerations | | |
| Y | N | Throat Swelling | Y | N | Do you perform monthly self exams? | | |
| Other: | | | Υ | N | Lumps, Masses or Discharge | | |
| | | Cardiovascular | Υ | N | Rash, Bruising or Swelling | | |
| Υ | N | Leg Swelling | Other: | | | | |
| Υ | N | Palpitations | | | Hematology | | |
| Υ | N | Shortness of Breath When Lying Flat | Υ | N | Anemia/ Blood Transfusion | | |
| Υ | N | Slow/ Rapid Heart Beat | Y | N | Easy Bruising/ Abnormal Bleeding | | |
| Other | : | | Υ | N | Swollen Lymph Nodes | | |
| | | Respiratory | Other | : | | | |
| Υ | N | Chest Pain/ Breathing | | | Gastrointestinal | | |
| Υ | N | Coughing or Wheezing | Υ | N | Blood in Stool or Black Tarry Stool | | |
| Y | N | Difficulty Breathing with Activity | Υ | N | Constipation or Diarrhea | | |
| Y | N | Shortness of Breath | Y | N | Nausea or Vomiting | | |
| Othe | r: | | Y | N | Pain or Bloating | | |
| | | Muscles / Joints | Othe | r: | | | |
| | | | | | | | |

Other:

Ν

Pain or Stiffness