

Demographics

Name (Last, First)							Age	
Street Address								
City					State			Zip
Home Telephone	()			Work Telephone		()		
Date of Birth				Occupation				
Marital Status	Single	Married	Separated	Divorced	Widowed	Common-law		Race
Spouse's Name								

Present Symptoms

Main Reason for Visit								
Symptoms (circle any that apply)	General/Constitutional	Weight loss	Weight gain	Fever	Night sweats			
	Eyes	Double vision	Tearing	Blind spots	Eye pain			
	Ears/Nose/Mouth/Throat	Headaches	Dizziness	Lightheadedness	Nose bleeding	Nasal obstruction	Dental difficulties	
	Cardiovascular	Bleeding gums	Dentures	Neck stiffness	Neck pain	Neck tenderness	Neck mass	
	Respiratory	Chest pain	Irregular heart beat	Fainting	Shortness of breath with exertion			
	Gastrointestinal	Shortness of breath lying down	Shortness of breath when waking at night					
	Genitourinary	Swelling	High blood pressure	Heart murmur	Varicosities	Phlebitis		
	Musculoskeletal	Painful extremity with movement						
	Skin/Breast	Wheezing	Cough	Coughing blood	Respiratory infections	Tuberculosis		
	Neurologic	Poor appetite	Difficulty swallowing	Indigestion	Abdominal pain	Heartburn	Burping	
	Psychiatric	Nausea	Vomiting	Vomiting blood	Yellow skin	Constipation	Diarrhea	Abnormal stools
	Endocrine	Flatulence	Hemorrhoids		Recent changes in bowel habits			
	Hematology/Lymphatic	Urgency	Frequency	Painful urination	Getting up at night to urinate			
Allergic/Immunologic	Blood in Urine	Frequent urination	Lack of urine	Stones	Urinary incontinence			
	Urinary infections	Nephritis	Vaginal discharge	Venereal disease				
	Joint pain	Limitation of motion	Muscular weakness	Muscle cramps				
	Rash	Itching	Pigmentation	Changes in hair growth or loss	Nail changes			
	Breast lumps	Breast tenderness	Breast swelling	Nipple discharge				
	Convulsions	Paralysis	Tremor	Incoordination	Difficulties with memory or speech			
	Sensory or motor disturbances		Problem with muscular coordination					
	Nervousness	Emotional problems	Anxiety	Depression	Previous psychiatric care			
	Hallucinations							
	Increased water intake		Hormone therapy	Abnormal growth	Intolerance to heat or cold			
	Anemia	Bleeding tendency	Previous transfusions and reactions		Rh incompatibility			
	Lymph node enlargement or tenderness							
	Reactions to drugs		Reaction to food	Reaction to insects				

Family History (Mark Those That Apply)

Disease	Father	Mother	Maternal Grandparents		Paternal Grandparents		Brothers / Sisters			Children
			Grandmother	Grandfather	Grandmother	Grandfather				
Living or Deceased (Age)	()	()	()	()	()	()				
Alcoholism										
Anemia										
Arthritis										
Asthma										
Bleeds Easily										
Cancer (type)										
Colon Polyps										
Diabetes										
Epilepsy										
Glaucoma										
Heart Disease										
High Cholesterol										
High Blood Pressure										
Kidney Disease/Stones										
Mental Illness										
Obesity										
Osteoporosis										
Stomach Ulcers										
Stroke										
Suicide										
Thyroid Disease										
Tuberculosis										
Other Inherited Disease										

Screening

<p>Pap Smear: The pap smear is a test that is performed to diagnose pre-cancerous changes of the cervix. Cancer of the cervix is a deadly disease that does not just appear overnight. It is generally preceded by a process called dysplasia. This is easily diagnosed by pap smear and can be cured with very conservative measures. The pap smear is obtained by placing a speculum into your vagina and exposing the cervix. A wooden spatula and a cervical brush are used to sample cells from your cervix. The American College of Obstetricians and Gynecologists recommend this test be performed after a woman becomes sexually active or when she reaches 18 years of age, whichever comes first. The test should be performed every year until 3 consecutive normal smears are obtained. For low risk patients, the interval of pap smears can be spaced out at your and your doctor's discretion.</p>		
<input type="checkbox"/> I do not need this test	<input type="checkbox"/> I had this test date: _____	<input type="checkbox"/> I believe that I need this test
<p>Hemoglobin: This is a blood test that measures the red blood cell volume in your blood stream. These cells are important for carrying oxygen in your body. A specimen is obtained by inserting a needle into a vein in your arm. Many processes can cause anemia, a condition where the hemoglobin is low. One of the most common causes of anemia is chronic bleeding like heavy menstrual periods or bleeding from the gastrointestinal tract. Other causes of anemia are inherited, due to chronic diseases, or due to poor diet. The American College of Obstetricians and Gynecologists recommend that people of Caribbean, Latin American, Asian, Mediterranean, or African Ancestry have this screening examination performed. Women with heavy menstrual flow should be screened as well.</p>		
<input type="checkbox"/> I do not need this test	<input type="checkbox"/> I had this test date: _____	<input type="checkbox"/> I believe that I need this test
<p>Urine Culture: Bacteria growing in the urine can easily be treated. Many women with infection in the urine present with symptoms like painful or frequent urination. Others don't have any symptoms. Diabetic patients are more likely to be harmed by chronic infections in the urine. The American College of Obstetricians and Gynecologists recommend that diabetics be screened.</p>		
<input type="checkbox"/> I do not need this test	<input type="checkbox"/> I had this test date: _____	<input type="checkbox"/> I believe that I need this test
<p>Mammogram: A mammogram is your best tool to detect breast cancer early. Early detection of breast cancer is the key to cure of this type of cancer. This is an xray of the breast that needs to be scheduled. It will not be performed on the date of the annual examination. The American College of Obstetricians and Gynecologists recommend that women with a sister, mother, or daughter diagnosed with breast cancer prior to menopause have a mammogram at 35 years of age. After 40 years of age, all women should be screened every 1-2 years. After 50, the test should be done every year.</p>		
<input type="checkbox"/> I do not need this test	<input type="checkbox"/> I had this test date: _____	<input type="checkbox"/> I believe that I need this test
<p>Fasting Glucose: Diabetes is a disease characterized by a high blood sugar. This problem can result in many complications like blindness, heart disease, amputations, kidney failure, and strokes. Early diagnosis and treatment can delay or prevent these problems. This test is obtained by drawing blood from a vein in your arm after fasting overnight. The American College of Obstetricians and Gynecologists recommend that this test be performed every 3-5 years in people who have a family history of diabetes, are obese, or developed diabetes in a previous pregnancy.</p>		
<input type="checkbox"/> I do not need this test	<input type="checkbox"/> I had this test date: _____	<input type="checkbox"/> I believe that I need this test
<p>Cholesterol: Cholesterol, if elevated, can result in blockages in your arteries. This can result in heart attacks. High cholesterol can be a result of inheritance or dietary factors. A high cholesterol can be lowered with lifestyle change, or if needed, with medication. This test is done by drawing blood from a vein in your arm. The American College of Obstetricians and Gynecologists recommend that this be tested every five years starting at 45 years of age. It should be done earlier in patients who have a personal or family history of premature coronary artery disease or in patients with a history of lipid disease in the family.</p>		
<input type="checkbox"/> I do not need this test	<input type="checkbox"/> I had this test date: _____	<input type="checkbox"/> I believe that I need this test
<p>Tests for sexually transmitted disease: Persons with one sexually transmitted disease are at risk for developing other sexually transmitted disease. These diseases include hepatitis B, HIV, syphilis, gonorrhea, and chlamydia. The tests are both blood tests that require blood be drawn from a vein in your arm plus a specimen obtained from your cervix at the time of a pelvic examination. The American College of Obstetricians and Gynecologists recommend that a woman with more than one sexual partner, or who has a partner, who has more than one partner, should consider being tested for sexually transmitted diseases.</p>		
<input type="checkbox"/> I do not need this test	<input type="checkbox"/> I had this test date: _____	<input type="checkbox"/> I believe that I need this test
<p>Rubella Immunity: Rubella is a viral infection that can cause a rash and fever. If you catch rubella during pregnancy, the fetus may develop a number of severe birth defects. This is completely preventable by vaccination. The American College of Obstetricians and Gynecologists recommend that if you have a testing of rubella immunity if you are of childbearing age and have not previously been documented to be immune. This test is a blood test and the sample is taken from a vein in your arm.</p>		
<input type="checkbox"/> I do not need this test	<input type="checkbox"/> I had this test date: _____	<input type="checkbox"/> I believe that I need this test
<p>Tuberculosis Skin Test: Tuberculosis is a serious public health issue. This disease is a lung infection that if left untreated is contagious and can cause death. With the emergence of the HIV epidemic, tuberculosis has made a comeback. The American College of Obstetricians and Gynecologists recommend that you be tested if you are HIV positive, in close contact with people who have known or suspected tuberculosis, if you have medical problems that make you more susceptible to complications if you contract the disease, abuse alcohol, use intravenous drugs, you are a resident of a long-term care facility (i.e., prison, mental institution, or nursing home), or work in a high-risk health care facility. This test is done by injecting a small amount of fluid into the skin of your forearm. The test needs to be read in the office at 48 to 72 hours after the injection.</p>		
<input type="checkbox"/> I do not need this test	<input type="checkbox"/> I had this test date: _____	<input type="checkbox"/> I believe that I need this test
<p>Lipid Profile: The American College of Obstetricians and Gynecologists recommend a lipid profile if your screening cholesterol is elevated, if you have a parent or sibling with elevated cholesterol, if you have diabetes, if you smoke, or if you have a close relative with premature coronary artery disease. This test will break down your cholesterol count into the good (HDL) and bad (LDL) cholesterol and get a more accurate reflection of the risk of developing coronary artery disease. This is a blood test the requires drawing a sample from a vein in your arm.</p>		
<input type="checkbox"/> I do not need this test	<input type="checkbox"/> I had this test date: _____	<input type="checkbox"/> I believe that I need this test
<p>Thyroid Stimulating Hormone: This is a test of a gland in your neck that regulates your metabolism. This is tested by drawing blood from a vein in your arm. The American College of Obstetricians and Gynecologists recommend that this test be offered to patients with a strong family history of thyroid disease or a personal history of autoimmune disease.</p>		
<input type="checkbox"/> I do not need this test	<input type="checkbox"/> I had this test date: _____	<input type="checkbox"/> I believe that I need this test
<p>Fecal Occult Blood: This is test for blood in your stool. Blood in the stool is an early warning sign of cancer of the gastrointestinal tract. You will be given a card that requires 3 separate specimens of your stool be collected and sent back for analysis. The American College of Obstetricians and Gynecologists recommend that you should be tested every one to two years until 50 years of age and then annually after age 50.</p>		
<input type="checkbox"/> I do not need this test	<input type="checkbox"/> I had this test date: _____	<input type="checkbox"/> I believe that I need this test
<p>Sigmoidoscopy: An additional screening tool for colon cancer is to directly observe the lower colon with a lighted scope. This procedure is generally performed by a physician with special training and might need to be scheduled. The American College of Obstetricians and Gynecologists recommend that this be performed every three to five years after the age of 50.</p>		
<input type="checkbox"/> I do not need this test	<input type="checkbox"/> I had this test date: _____	<input type="checkbox"/> I believe that I need this test
<p>Colonoscopy: To screen for colon cancer the entire length of the colon can be observed with a lighted scope. This procedure is generally performed by a physician with special training and might need to be scheduled. The American College of Obstetricians and Gynecologists recommend that colonoscopy be performed in patients with a history of inflammatory bowel disease or colon polyps or a family history of familial polyposis, colon cancer, or cancer family syndrome.</p>		
<input type="checkbox"/> I do not need this test	<input type="checkbox"/> I had this test date: _____	<input type="checkbox"/> I believe that I need this test

Immunizations

Tetanus Booster: A tetanus shot is important to prevent a potentially fatal disease called tetanus, more commonly referred to as lockjaw. The American College of Obstetricians and Gynecologists recommend that you be vaccinated every ten years.

<input type="checkbox"/> I do not need this vaccination	<input type="checkbox"/> I had this vaccination date: _____	<input type="checkbox"/> I believe that I need this vaccination
<p>Rubella vaccine: The American College of Obstetricians and Gynecologists recommend this vaccine be given to women of childbearing age who are not immune to rubella. Rubella, if contracted in early pregnancy, has devastating effects on the fetus. This is completely preventable.</p>		
<input type="checkbox"/> I do not need this vaccination	<input type="checkbox"/> I had this vaccination date: _____	<input type="checkbox"/> I believe that I need this vaccination
<p>Hepatitis B vaccine: This is potentially fatal infection of the liver. It is preventable with a series of three vaccinations. The American College of Obstetricians and Gynecologists recommend this vaccine be given to women whose jobs expose them to blood and body fluids. Other candidates for this vaccine include intravenous drug users, patients who receive blood products, people who have household or sexual contact with hepatitis B virus carriers, prostitutes, and people with multiple sexual partners.</p>		
<input type="checkbox"/> I do not need this vaccination	<input type="checkbox"/> I had this vaccination date: _____	<input type="checkbox"/> I believe that I need this vaccination
<p>Influenza vaccine: The influenza virus causes a self-limited respiratory infection in most people. However, elderly or ill people can develop fatal complications from infection. The American College of Obstetricians and Gynecologists recommend this vaccine be administered annually prior to the flu season starting at 55 years of age. Other candidates for the vaccine include residents of chronic care facilities, patients with cardiac or metabolic diseases (ex, diabetes, kidney disease), patients whose immune systems are compromised, and pregnant women in the second and third trimester.</p>		
<input type="checkbox"/> I do not need this vaccination	<input type="checkbox"/> I had this vaccination date: _____	<input type="checkbox"/> I believe that I need this vaccination
<p>Pneumococcal vaccine: A bacterial infection that causes pneumonia and meningitis caused by a streptococcus can be prevented by vaccination. The American College of Obstetricians and Gynecologists recommend this vaccine be given once lifetime to residents of chronic care facilities, patients with cardiac or metabolic diseases (ex, diabetes, kidney disease), patients whose immune systems are compromised, patients with sickle cell disease, Hodgkin's disease, alcoholism, cirrhosis, or multiple myeloma.</p>		
<input type="checkbox"/> I do not need this vaccination	<input type="checkbox"/> I had this vaccination date: _____	<input type="checkbox"/> I believe that I need this vaccination
<p>Varicella vaccine: Chicken pox is a self-limiting viral infection. In adults, the disease can be more severe and result in a potentially fatal lung infection. This is more likely to happen if the disease is contracted in pregnancy. The American College of Obstetricians and Gynecologists recommend this vaccine be given to women of childbearing age who are not already immune.</p>		
<input type="checkbox"/> I do not need this vaccination	<input type="checkbox"/> I had this vaccination date: _____	<input type="checkbox"/> I believe that I need this vaccination

Social History

Do you smoke cigarettes?	<input type="checkbox"/> NO	<input type="checkbox"/> YES	If so, how many cigarettes per day?	
Do you drink alcohol?	<input type="checkbox"/> NO	<input type="checkbox"/> YES	If so, how many drinks per week?	
Do you use drugs?	<input type="checkbox"/> NO	<input type="checkbox"/> YES	If so, which ones?	
Do you use seatbelts?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Do you exercise?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Have you ever received a blood transfusion?	<input type="checkbox"/> NO	<input type="checkbox"/> YES	Are you under a lot of stress?	<input type="checkbox"/> NO <input type="checkbox"/> YES
Place of birth:	If you were not born in this country, how long have you lived here?			

Health Questionnaires

Partner Violence Questionnaire				
Have you been hit, kicked, punched or otherwise hurt by someone within the past year? If so, by whom? _____			<input type="checkbox"/> NO	<input type="checkbox"/> YES
Do you feel unsafe in your current relationship?			<input type="checkbox"/> NO	<input type="checkbox"/> YES
Is there a partner from a previous relationship who is making you feel unsafe now?			<input type="checkbox"/> NO	<input type="checkbox"/> YES
Depression Questionnaire				
I am unable to do the things I used to do.	<input type="checkbox"/> NO	<input type="checkbox"/> YES	I feel hopeless about the future.	<input type="checkbox"/> NO <input type="checkbox"/> YES
I can't make decisions.	<input type="checkbox"/> NO	<input type="checkbox"/> YES	I feel sluggish/restless.	<input type="checkbox"/> NO <input type="checkbox"/> YES
I am gaining/losing weight.	<input type="checkbox"/> NO	<input type="checkbox"/> YES	I get tired for no reason.	<input type="checkbox"/> NO <input type="checkbox"/> YES
I am sleeping too little (or too much).	<input type="checkbox"/> NO	<input type="checkbox"/> YES	I feel unhappy.	<input type="checkbox"/> NO <input type="checkbox"/> YES
			I think about killing myself.	<input type="checkbox"/> NO <input type="checkbox"/> YES
Genetic Screening Questionnaire (Answer if you are of child bearing age and interested in pregnancy)				
Have you, your partner, or anyone in either of your families ever had any of the following disorders:				
-- Down Syndrome	<input type="checkbox"/> NO	<input type="checkbox"/> YES	-- Any chromosomal abnormality	<input type="checkbox"/> NO <input type="checkbox"/> YES
-- Spina Bifida or anencephaly	<input type="checkbox"/> NO	<input type="checkbox"/> YES	-- Hemophilia	<input type="checkbox"/> NO <input type="checkbox"/> YES
-- Muscular Dystrophy	<input type="checkbox"/> NO	<input type="checkbox"/> YES	-- Cystic fibrosis	<input type="checkbox"/> NO <input type="checkbox"/> YES
-- If yes, what relationship:				
Do you, your partner, or anyone in either of your families have a chromosomal disorder not listed above?			<input type="checkbox"/> NO	<input type="checkbox"/> YES
Do you or your partner have a birth defect?			<input type="checkbox"/> NO	<input type="checkbox"/> YES
Are you and your partner blood relatives?			<input type="checkbox"/> NO	<input type="checkbox"/> YES
In any previous marriages, has you or your partner had a stillborn child or three first trimester pregnancy losses?			<input type="checkbox"/> NO	<input type="checkbox"/> YES
Are you or your partner of Jewish or Cajun ancestry?			<input type="checkbox"/> NO	<input type="checkbox"/> YES
Are you or your partner Hispanic or African American?			<input type="checkbox"/> NO	<input type="checkbox"/> YES
Are you or your partner of Italian, Greek, or Mediterranean ancestry?			<input type="checkbox"/> NO	<input type="checkbox"/> YES
Are you or your partner of Philippine, Chinese, or Southeast Asian ancestry?			<input type="checkbox"/> NO	<input type="checkbox"/> YES

Provider Notes

Empty box for provider notes.

Initial Gynecologic Examination

Female Genitourinary and Physical Examination

Constitutional	*Vital Signs	BP (sitting): ____/____/____ BP (standing): ____/____/____ BP (supine): ____/____ Pulse: ____ regular / irregular Respirations: ____ Height: ____ Weight: ____
	*General Appearance	development: normal/abnormal nutrition: normal/malnourished body habitus: thin/normal/obese deformities: yes/no attention to grooming: yes/no
Head and Face		
Eyes		
ENT		
Neck	*Neck	masses: yes/no appearance: normal/abnormal symmetry: yes/no tracheal position: midline/shifted crepitus: yes/no
	*Thyroid	enlargement: yes/no tenderness: yes/no mass: yes/no
Respiratory	*Respiratory Effort	retractions: yes/no accessory muscles: yes/no diaphragm excursion: normal/abnormal
	*Auscultation of the Lungs	breath sounds: normal/abnormal adventitious sounds: yes/no rubs: yes/no
Cardiovascular	*Auscultation of the Heart	
	*Peripheral Vasc	edema: yes/no varicosities: yes/no pulses: normal/abnormal temperature: cool/warm/normal tenderness: yes/no
Breast		
Abdomen	*Abdomen	masses: yes/no tenderness: yes/no
	*Hernia	
	*Liver/Spleen	
	*Hemoccult	
Genitourinary	*Ext Genital	appearance: normal/abnormal hair distribution: normal/abnormal lesions: yes/no
	*Uret Meatus	size: normal/abnormal location: normal/abnormal lesions: yes/no prolapse: yes/no
	*Urethra	masses: yes/no tenderness: yes/no scarring: yes/no
	*Bladder	fullness: yes/no masses: yes/no tenderness: yes/no
	*Vagina	appearance: normal/abnormal estrogen effect: yes/no discharge: yes/no lesions: yes/no pelvic support: normal/abnormal cystocele: yes/no rectocele: yes/no
	*Cervix	appearance: normal/abnormal lesions: yes/no discharge: yes/no
	*Uterus	size: small/normal/enlarged contour: normal/abnormal position: anteverted/midline/retroverted mobility: mobile/non-mobile tenderness: yes/no consistency: soft/hard/normal descent: yes/no
	*Adnexae parametria	masses: yes/no tenderness: yes/no organomegaly: yes/no nodularity: yes/no
	*Anus Perineum	
	*Digital rectal exam	tone: normal/abnormal hemorrhoids: yes/no rectal masses: yes/no
Lymphatic		
Nodes (neck, axillae, groin): yes/no		
Musculoskeletal	Extremities	
Skin	*Skin Lesions	rashes: yes/no lesions: yes/no ulcers: yes/no
Neurological/ Psychiatric	*Orientation	
	*Mood	

