

GYNECOLOGY - HISTORY & PHYSI

DATE

NAME

MARITAL STATUS
S M W D SEP

DATE OF BIRTH

Formedic

ADDRESS

PHONE (H)

(O)

EMPLOYER / OCCUPATION

REFERRED BY

MENARCHE G P A L MENST Hx - LNMP

CYCLE

HEAVY MODERATE
 LIGHT

PATTERN - REGULAR Y N

FREQUENCY

DURATION

SPOTTING Y N PAIN BLOATING Y N

LAST PAP TEST

NORM
 ABN

CONTRACEPTION - CURRENT METHOD

PAST METHOD(S)

MAMMOGRAM

NORM
 ABN

STD

B. VAG

HPV

HIV

MENOPAUSE

HOT FLASHES VAGINAL DRYNESS NIGHT SWEATS MEMORY / CONCENTRATION TREATMENT

SEXUAL PROBLEMS

LIBIDO ORGASMIC DYSFUNCT DYSpareunia VAGINISMUS URINARY TRACT INFECTIONS FREQUENCY INCONTINENCE URGENCY (X)

CC & HISTORY OF PRESENT ILLNESS

O H I S T O R Y	HABITS		CIG		ALCOHOL		oz/wk	COFFEE	CUPS/DAY	REGULAR EXERCISE		STREET DRUGS		
	MO/YR	GEST AGE	LABOR	DEL / TYPE	WT	SEX	REMARKS	MO/YR	GEST AGE	LABOR	DEL / TYPE	WT	SEX	REMARKS

PAST MEDICAL & FAMILY HISTORY - (✓) NORMAL (X) ABNORMAL (USE REFERENCE #'S TO DETAIL POSITIVE FINDINGS)

	SELF	FAM		SELF	FAM
1. WT LOSS / GAIN	<input type="checkbox"/>	<input type="checkbox"/>	13. ANEMIA / BLOOD DISEASE	<input type="checkbox"/>	<input type="checkbox"/>
2. HEADACHES / MIGRAINE	<input type="checkbox"/>	<input type="checkbox"/>	14. BLOOD TRANSFUSION	<input type="checkbox"/>	<input type="checkbox"/>
3. HEART DIS (MVP - RHD)	<input type="checkbox"/>	<input type="checkbox"/>	15. VARICOSE V / PHLEBITIS	<input type="checkbox"/>	<input type="checkbox"/>
4. HYPERTENSION	<input type="checkbox"/>	<input type="checkbox"/>	16. THYROID DISEASE	<input type="checkbox"/>	<input type="checkbox"/>
5. RESPIRATORY DIS	<input type="checkbox"/>	<input type="checkbox"/>	17. DIABETES	<input type="checkbox"/>	<input type="checkbox"/>
6. BREAST DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	18. CANCER	<input type="checkbox"/>	<input type="checkbox"/>
7. JAUNDICE / HEPATITIS	<input type="checkbox"/>	<input type="checkbox"/>	19. EPILEPSY / NEUR DISEASE	<input type="checkbox"/>	<input type="checkbox"/>
8. GALL BLADDER DIS	<input type="checkbox"/>	<input type="checkbox"/>	20. ARTHRITIS / OSTEOPOROSIS	<input type="checkbox"/>	<input type="checkbox"/>
9. H. HERNIA / PEP ULCER	<input type="checkbox"/>	<input type="checkbox"/>	21. SKIN DISEASES	<input type="checkbox"/>	<input type="checkbox"/>
10. BOWEL DISORDERS	<input type="checkbox"/>	<input type="checkbox"/>	22. EXCESSIVE SWEATING	<input type="checkbox"/>	<input type="checkbox"/>
11. KIDNEY DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	23. ANXIETY DEPRESSION	<input type="checkbox"/>	<input type="checkbox"/>
12. URINARY INCONT / INFECT	<input type="checkbox"/>	<input type="checkbox"/>	24. SLEEP DIFFICULTY	<input type="checkbox"/>	<input type="checkbox"/>

IMMUNIZATIONS (YEAR)	TETANUS /Td	FLU	HEP A	HEP B	SHINGLES	HPV	STD - # OF ENCOUNTERS	TRAVEL ABROAD

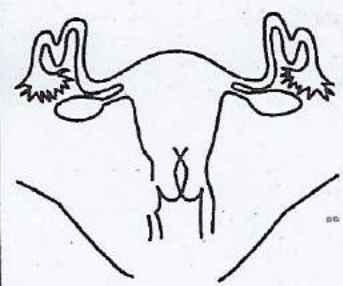
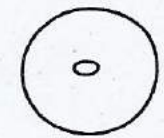
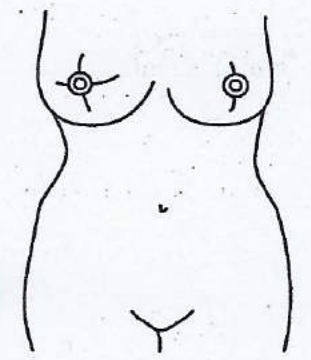
H O S P	MO / YR	ILLNESS / OPERATION	MO / YR	ILLNESS / OPERATION

MEDICATIONS	CALCIUM SUPPLEMENTS & HERBAL REMEDIES	ALLERGIES

PHYSICAL EXAM

Formedic

	<input type="checkbox"/> N	<input type="checkbox"/> (X) ABN	HT	WT	BMI	B.P.	P.
1. APPEARANCE	<input type="checkbox"/>	<input type="checkbox"/>					
2. SKIN	<input type="checkbox"/>	<input type="checkbox"/>					
3. HEENT	<input type="checkbox"/>	<input type="checkbox"/>					
4. THYROID	<input type="checkbox"/>	<input type="checkbox"/>					
5. LYMPH NODES	<input type="checkbox"/>	<input type="checkbox"/>					
6. HEART	<input type="checkbox"/>	<input type="checkbox"/>					
7. LUNGS	<input type="checkbox"/>	<input type="checkbox"/>					
8. BREASTS	<input type="checkbox"/>	<input type="checkbox"/>					
9. NODES - AXILL	<input type="checkbox"/>	<input type="checkbox"/>					
- SUPRACLAV	<input type="checkbox"/>	<input type="checkbox"/>					
10. ABDOMEN	<input type="checkbox"/>	<input type="checkbox"/>					
11. EXTREMITIES	<input type="checkbox"/>	<input type="checkbox"/>					
12. M. SKELETAL	<input type="checkbox"/>	<input type="checkbox"/>					
13. NEUROLOGIC	<input type="checkbox"/>	<input type="checkbox"/>					



GYNECOLOGICAL EXAM

EXT. GENITALIA

B U S

VAGINA

CERVIX

UTERUS <input type="checkbox"/>	POSITION	SHAPE	SIZE	MOBILITY

ADNEXA

RECTUM

INVESTIGATIONS

PAP TEST <input type="checkbox"/>	SEROLOGY <input type="checkbox"/>	PREG TEST <input type="checkbox"/>
ULTRASOUND <input type="checkbox"/>	WET MOUNT <input type="checkbox"/>	CBC <input type="checkbox"/>
MAMMOGRAM <input type="checkbox"/>	KOH WHIFF TEST <input type="checkbox"/>	URINE ANALYSIS <input type="checkbox"/>
COLPOSCOPY <input type="checkbox"/>	pH TEST <input type="checkbox"/>	C&S <input type="checkbox"/>
HYSTEROSCOPY <input type="checkbox"/>	CULTURES <input type="checkbox"/>	CHOL/TRIG <input type="checkbox"/>
<input type="checkbox"/>	G.C. ORAL <input type="checkbox"/>	THYROID <input type="checkbox"/>
<input type="checkbox"/>	CX <input type="checkbox"/>	STOOL OCCULT <input type="checkbox"/>
<input type="checkbox"/>	RECT <input type="checkbox"/>	BLOOD <input type="checkbox"/>
<input type="checkbox"/>	URET <input type="checkbox"/>	BONE DENSITY <input type="checkbox"/>
<input type="checkbox"/>	CHLAMYDIA <input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	HIV SCREEN <input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	HPV SCREEN <input type="checkbox"/>	<input type="checkbox"/>

DIAGNOSIS

TREATMENT

NEXT APPOINTMENT