

Patient Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Date \_\_\_\_\_

### Physical/New Patient History

( ) New Patient      ( ) Established Patient      ( ) Consultation

Primary Care Physician \_\_\_\_\_ Who sent you? \_\_\_\_\_

Other Health Care Providers: \_\_\_\_\_

Age: \_\_\_\_\_ Married/ Single/ Divorced/ Widow (circle one)

Why Are You Here Today?

Current Medications: None ( )  
List all medicines, vitamins, herbs,  
birth control pills, hormones,  
calcium:

ALLERGIES (describe reaction):

None ( )

1<sup>st</sup> day of last menstrual period \_\_/\_\_/\_\_ # of days of bleeding \_\_\_\_\_ cycles regular? \_\_\_\_

Age periods began: \_\_\_\_\_

Date of last Pap test: \_\_/\_\_/\_\_ Results: \_\_\_\_\_

Date of last mammogram: \_\_/\_\_/\_\_ Results: \_\_\_\_\_

Date of last colorectal screening: \_\_/\_\_/\_\_ Results: \_\_\_\_\_

### Past History

All Surgeries:

**Obstetrical History:**

# of times pregnant \_\_\_\_\_

# of living children \_\_\_\_\_

vaginal births \_\_\_\_\_ C-sections \_\_\_\_\_

miscarriages \_\_\_\_\_ terminations \_\_\_\_\_

Any pregnancy complications? \_\_\_\_\_

Past or Current Illnesses:

**Gynecologic History:**

Birth control method: \_\_\_\_\_

Past sexually transmitted disease:

Herpes \_\_\_ HPV \_\_\_ Chlamydia \_\_\_

Do you want STD testing today? \_\_\_\_

Explain any history of "female  
problems": \_\_\_\_\_

Injuries in the last year:

Immunizations up-to-date? \_\_yes \_\_no

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Date \_\_\_\_\_

### Family History

(your family including grandparents)

Mother:  living  deceased-cause: \_\_\_\_\_ age: \_\_\_\_\_  
Father:  living  deceased-cause: \_\_\_\_\_ age: \_\_\_\_\_  
Siblings: number living: \_\_\_\_\_ number deceased: \_\_\_\_\_ cause/age: \_\_\_\_\_  
Children: number living: \_\_\_\_\_ number deceased: \_\_\_\_\_ cause/age: \_\_\_\_\_

Has anyone in your family (including grandparents) had:

diabetes: \_\_\_\_\_  heart disease: \_\_\_\_\_  high cholesterol: \_\_\_\_\_  
 cancer: \_\_\_\_\_  high blood pressure: \_\_\_\_\_  blood clots: \_\_\_\_\_  
 thyroid: \_\_\_\_\_  osteoporosis: \_\_\_\_\_  depression: \_\_\_\_\_  
 genetic problems: \_\_\_\_\_  other: \_\_\_\_\_

### Social History (comments)

Tobacco Use	Yes	No	_____
Alcohol Use	Yes	No	_____
Street Drug Use	Yes	No	_____
Abusive/Violent Relationships	Yes	No	_____
Health Hazards at Home/Work	Yes	No	_____
Seat Belt Use	Yes	No	_____
Special Diet	Yes	No	_____
Regular Exercise	Yes	No	_____
Caffeine Intake	Yes	No	_____
Current Occupation:	_____		

### Cultural/Religious

- Do you have any preferences related to your cultural/religious beliefs? Yes No
- If so, please explain: \_\_\_\_\_
- Is English your first language? Yes No If not, what is? \_\_\_\_\_
- Do you need an interpreter? Yes No
- Do you use sign language? Yes No

### Pain Assessment

Are you presently having any pain? Yes No  
If so, where is it located? \_\_\_\_\_  
What does it feel like? \_\_\_\_\_  
When did it start? \_\_\_\_\_ What makes it better? \_\_\_\_\_  
What makes it worse? \_\_\_\_\_  
Intensity (rate on a scale of 0-10; 0= no pain, 10 = extreme pain) \_\_\_\_\_  
Are you being treated for this? Yes No If so, by whom? \_\_\_\_\_

Patient Name \_\_\_\_\_ Birthdate: \_\_\_\_\_ Date: \_\_\_\_\_

**Review of Systems/Current Concerns**

1. General Health	<input type="checkbox"/> None	<input type="checkbox"/> Fatigue <input type="checkbox"/> Loss of Appetite	<input type="checkbox"/> Weight Change > or < 20 lbs.	<input type="checkbox"/> Other
2. Eyes, Ears, Nose & Throat	<input type="checkbox"/> None	<input type="checkbox"/> Vision Change	<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Sinusitis <input type="checkbox"/> Other
3. Cardiovascular	<input type="checkbox"/> None	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Swelling	<input type="checkbox"/> Palpitations <input type="checkbox"/> Other
4. Respiratory	<input type="checkbox"/> None	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Cough	<input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Other
5. Gastrointestinal	<input type="checkbox"/> None	<input type="checkbox"/> Nausea/Vomiting <input type="checkbox"/> Indigestion	<input type="checkbox"/> Diarrhea <input type="checkbox"/> Bleeding	<input type="checkbox"/> Constipation <input type="checkbox"/> Other
6. Genitourinary	<input type="checkbox"/> None	<input type="checkbox"/> Pain/Pressure with Urination <input type="checkbox"/> Frequent Urination <input type="checkbox"/> Abnormal or Painful Periods <input type="checkbox"/> Abnormal Vaginal Bleeding <input type="checkbox"/> Abnormal Vaginal Discharge	<input type="checkbox"/> Leaking Urine <input type="checkbox"/> Blood in Urine <input type="checkbox"/> PMS <input type="checkbox"/> Painful Intercourse	<input type="checkbox"/> Other
7. Musculoskeletal	<input type="checkbox"/> None	<input type="checkbox"/> Muscle or Joint Pain		<input type="checkbox"/> Other
8. Skin	<input type="checkbox"/> None	<input type="checkbox"/> Rash	<input type="checkbox"/> Sores	<input type="checkbox"/> Other
9. Breast	<input type="checkbox"/> None	<input type="checkbox"/> Lumps/Masses <input type="checkbox"/> Skin or Nipple changes	<input type="checkbox"/> Discharge	<input type="checkbox"/> Pain/Tenderness <input type="checkbox"/> Other
10. Neurologic	<input type="checkbox"/> None	<input type="checkbox"/> Dizziness <input type="checkbox"/> Memory Changes	<input type="checkbox"/> Headaches	<input type="checkbox"/> Numbness <input type="checkbox"/> Seizures <input type="checkbox"/> Other
11. Psychiatric	<input type="checkbox"/> None	<input type="checkbox"/> Depression	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Counseling <input type="checkbox"/> Other
12. Endocrine	<input type="checkbox"/> None	<input type="checkbox"/> Hot Flashes <input type="checkbox"/> Hair Loss	<input type="checkbox"/> Diabetes <input type="checkbox"/> Low Thyroid	<input type="checkbox"/> High Thyroid <input type="checkbox"/> Other
13. Blood/Lymph	<input type="checkbox"/> None	<input type="checkbox"/> Bleeding	<input type="checkbox"/> Bruises	<input type="checkbox"/> Swollen Glands <input type="checkbox"/> Other

PATIENT NAME \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ DATE \_\_\_\_\_

**PHYSICAL EXAMINATION**

Vital Signs: Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Pressure (sitting): \_\_\_\_\_ Pulse: \_\_\_\_\_  
Time/Initials: \_\_\_\_\_

General Appearance:  Well Developed  Other  Well-groomed  No deformities  
 Well Nourished  Other  Obese  Normal Habitus

**URINALYSIS:**

TIME/INITIALS: \_\_\_\_\_ CULTURE SENT: YES NO  
Leukocytes \_\_\_\_\_ PH \_\_\_\_\_ Protein \_\_\_\_\_ Glucose \_\_\_\_\_ Ketones \_\_\_\_\_ Blood \_\_\_\_\_

**NECK:**  NORMAL  ABNORMAL \_\_\_\_\_  
**THYROID**  NORMAL  ABNORMAL \_\_\_\_\_

**RESPIRATORY**  NORMAL  ABNORMAL \_\_\_\_\_  
**LUNGS**  CLEAR  ABNORMAL \_\_\_\_\_

**CARDIOVASCULAR**

-Auscultate Heart Sounds  NORMAL  ABNORMAL \_\_\_\_\_  
-Peripheral Vascular  NORMAL  ABNORMAL \_\_\_\_\_

**GASTROINTESTINAL**

-Abdomen  NORMAL  ABNORMAL \_\_\_\_\_  
-Hernia  NONE  PRESENT \_\_\_\_\_  
-Liver  NORMAL  ABNORMAL \_\_\_\_\_  
-Spleen  NORMAL  ABNORMAL \_\_\_\_\_  
-Stool/Guicac if indicated  NORMAL  ABNORMAL \_\_\_\_\_

**LYMPHATIC**

Palpation of nodes (choose all that are indicated)

-Neck  NORMAL  ABNORMAL \_\_\_\_\_  
-Axilla  NORMAL  ABNORMAL \_\_\_\_\_  
-Groin  NORMAL  ABNORMAL \_\_\_\_\_  
-Other site  NORMAL  ABNORMAL \_\_\_\_\_

**SKIN**

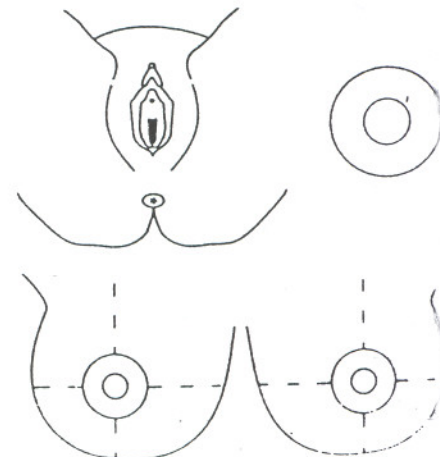
-Inspected/Palpated  NORMAL  ABNORMAL \_\_\_\_\_

**NEUROLOGIC/PSYCHIATRIC**

-Orientation  Time  Place  Person Comments: \_\_\_\_\_  
-Mood/Affect  Normal  Depressed  Anxious  Agitated  Other \_\_\_\_\_

**GYNECOLOGIC:**

-Breasts  NORMAL  ABNORMAL \_\_\_\_\_  
-Urethral Meatus  NORMAL  ABNORMAL \_\_\_\_\_  
-Urethra  NORMAL  ABNORMAL \_\_\_\_\_  
-Bladder  NORMAL  ABNORMAL \_\_\_\_\_  
-Vagina/Support  NORMAL  ABNORMAL \_\_\_\_\_  
-Cervix  NORMAL  ABNORMAL \_\_\_\_\_  
-Uterus  NORMAL  ABNORMAL \_\_\_\_\_  
-Adnexa  NORMAL  ABNORMAL \_\_\_\_\_  
-Perineum  NORMAL  ABNORMAL \_\_\_\_\_  
-Rectal/Anus  NORMAL  ABNORMAL \_\_\_\_\_



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### MEDICAL DECISION MAKING

**TEST(S) ORDERED:**

- LABORATORY
- \_\_\_ PAP TEST
- \_\_\_ WET MOUNT
- \_\_\_ U/A \_\_\_ C&S
- \_\_\_ CHLAMYDIA CULTURE
- \_\_\_ GONORRHEA CULTURE
- \_\_\_ OTHER: \_\_\_\_\_

**REVIEW OF RECORDS:**

- PREVIOUS TEST RESULTS: \_\_\_\_\_
- DISCUSSION OF TEST RESULTS WITH PERFORMING HEALTH CARE PROVIDER \_\_\_\_\_
- INDEPENDENT REVIEW OF IMAGE/SPECIMEN: \_\_\_\_\_
- OLD RECORDS REVIEWED & SUMMARIZED: \_\_\_\_\_
- HISTORY OBTAINED FROM OTHER SOURCES: \_\_\_\_\_

RADIOLOGY/ULTRASOUND

- \_\_\_ MAMMOGRAM
  - \_\_\_ BREAST ULTRASOUND
  - \_\_\_ PELVIC ULTRASOUND
  - \_\_\_ BONE DENSITY
  - \_\_\_ OTHER: \_\_\_\_\_
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### DIAGNOSIS/MANAGEMENT OPTIONS

**ASSESSMENT:**

**PLAN:**

**PATIENT COUNSELED ABOUT:**

- \_\_\_ SBE    \_\_\_ CALCIUM    \_\_\_ DIET    \_\_\_ EXERCISE    \_\_\_ SMOKING CESSATION
- \_\_\_ FOLIC ACID RDA                      \_\_\_ PREVENTION SCREENING GUIDELINES
- \_\_\_ STDS    \_\_\_ BIRTH CONTROL    \_\_\_ PRECONCEPTIONAL COUNSELING
- \_\_\_ HRT    \_\_\_ MENOPAUSE    \_\_\_ PERIMENOPAUSE

MINUTES COUNSELED: \_\_\_\_\_ TOTAL ENCOUNTER TIME: \_\_\_\_\_

**SIGNATURE:** \_\_\_\_\_

**DATE:** \_\_\_\_\_

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