Initial Gynecology Profile

INITIAL PHYSICAL FORM			
Height			
Weight			
Blood Pressure			
Pelvic Exam	Normal	Abn	NE
Ext. genitalia			
Vagina			
Cervix			
Uterus			
Ad nexus			
Rectum			
General Physical	Normal	Abn	NE
Skin			
HEENT			
Neck			
Chest			
Breasts			
Heart			
Lungs			
Abdomen			
Musculoskeletal			
Extremities			
Neurological			

Nutritional Assessment	
Not performed	
Apparently Adequate	
Apparently Inadequate	
Excessive caloric intake	

Check and Detail all Positive findings

LAB TESTS
Hgb
Hct
WBC
Differential
Pregnancy
HIV
Gonorrhea
Chlamydia
HSV
VDRL Serology
Hepatitis
PAP Smear
Wet Mount
Culture
Stool Occult Blood
Blood Glucose
Cholesterol
Thyroid Screen
Biopsy
Mammogram

Diagnosis and Treatment Plans: PAP GC Chlamydia Other Counseling/Education
SBE STD Facts E.C.P.

Signature: ____

Examination Date: ___/___/_____

Patient Identification (Please Print)	
Patient's Name:	Telephone:
Address:	Daye of Birth:
City:	Marital Status: S M D W
Reason for Visit:	**Medical Allergy / Sensitivity**

Pregnancy History (complete all information)

# of pregnancies:		# of premature births:		# of miscarriages:		# of spontaneous abortions:		# living children:	

Medical History

Have you or any members of your family had:	You	Your family
High cholesterol Heart disease Rheumatic Fever High blood pressure Asthma Tuberculosis Thyroid problems Liver disease Stomach Bowels Gall bladder problems Kidney problems AIDS (HIV) Hepatitis Anemia blood disorder Blood transfusion Allergies Cancer Infertility Gonorrhea Herpes (HSV) Condyloma (HPV) Syphilis Birth defects/Inherited disease Sexual abuse/Domestic problems Breast Problems Female Sexual Problems Chlamydia No known medical problems		
Hospitalizations List operations/serious illnesses that required hospitalization:		

Menstrual History

First day of last menstrual period:	____/____/_____	
Menarche (age of first period)	Interval (days between periods)	Length of period
Year:	Days:	Days:

Abnormalities					
Discharge		Excessive bleeding		Pain	

Contraceptive History	
Types	Dates Used
Oral	
IUD	
Depo Provera	
Diaphragm	
Spermicidal	
Condoms	
Other	

Lifestyle

-Did your mother take DES or any other hormone when pregnant with you?

- Have you ever had a Pap test?
If yes, date of your last pap test
______/______/___

- Have you ever had abnormal Pap test results?

- Are you sexually active

- Do you have more than one Partner

- Is intercourse painful for you

- Do you do monthly breast Exams

- Have you had a mammogram
If yes, date of your last mammogram
____/____/____

- Do you exercise on a regular basis
If yes, Type of exercise__________
Hours per week
____

Month:	Year	Complications Yes	No

Do you use any of the following (enter Type):		
Alcohol		
Tobacco		
Caffeine		
Non Prescription drugs		
Street Drugs		

Notes