ID No.: ______________

Today's Date: ____ / ____ / __

I. PATIENT INDENTIFICATION (PLEASE PRINT)

Patient's Name: ______________________

Address: ______________________

____

Home Telephone No.: (______) ______________

Work Telephone No.: (______) ______________

Type of Insurance: ______________

Policy #: ______________

Date of Birth: ____ / ____ / ____ Age: ______

Marital Status: ❑ S ❑ M ❑ D ❑ Sep ❑ W

Race: ______ Religion: ______

Education: ____ years Occupation: ______

Employer: ______________

ReferringPhysican: ______________

Primary Physician: ______________

II. REASON FOR SEEING DOCTOR: ______________________

____

III. MEDICAL HISTORY *(Check the appropriate box)*

Have you or any members of your family had:

	You	Your Family
1. High Cholesterol	❑	❑
2. Heart Disease	❑	❑
3. Rheumatic Fever	❑	
4. High Blood Pressure	❑	❑
5. Asthma	❑	
6. Tuberculosis	❑	
7. Diabetes	❑	❑
8. Thyroid Problems	❑	❑
9. Liver Disease	❑	
10. Stomach, Bowel or Gall Bladder Problems	❑	
11. Kidney or Bladder Problems	❑	
12. AIDS (HIV)	❑	❑
13. Hepatitis (type___)	❑	❑
14. Anemia or Blood Disorder	❑	❑

Check and detail positive findings below. Use reference numbers.

	You
15. Blood Transfusion	❑
16. Allergies	❑
17. Breast Problems	❑
18. Cancer	❑
19. Infertility	❑
20. Female or Sexual Problems	❑
21. Chlamydia	❑
22. Gonorrhea	❑
23. Herpes (HSV)	❑
24. Syphilis	❑
25. Birth Defects or Inherited Diseases	❑
26. Sexual Abuse or Domestic Violence	❑
27. Other Medical Problems	❑
28. **No Known Medical Problems**	❑

IV. HOSPITALIZATIONS

Please list those operations or serious illnesses that you have had which required hospitalization. If you have had more than six, check this box. ❑ **Do not include pregnancies here.**

Month/Year	Illness or Operation	Attending Physician's Name	Complications No Yes
/			❑ ❑
/			❑ ❑
/			❑ ❑
/			❑ ❑
/			❑ ❑
/			❑ ❑

Physicians Use Only

V. PREGNANCY HISTORY *(Complete all information)*

# of Pregnancies	# of Premature Births	# of Miscarriages	# of Spontaneous Abortions	# of Induced Abortions	# of Living Children

# of Term Births	Born Month/ Year	Baby's Sex	Weight at Birth	Weeks Pregnant (Term=40 Wks)	Hours in Labor	Type of Delivery	Type of Anesthesia	Complications No Yes
1	/		lbs. oz.					❑ ❑
2	/		lbs. oz.					❑ ❑
3	/		lbs. oz.					❑ ❑
4	/		lbs. oz.					❑ ❑
5	/		lbs. oz.					❑ ❑
6	/		lbs. oz.					❑ ❑
7	/		lbs. oz.					❑ ❑

Patient's Signature: ______________ Physician's Signature: ______________

VI. Please answer the following questions by putting an (X) in the box next to the word Yes or No, except where you are asked for specific information.

If a question doesn't apply, skip it and go on to the next one.

If for any reason you can't or don't want to answer a question, put a large dot (•) in the Yes or information space.

MENSTRUATION

If you have not begun to menstruate, please begin with question 12.

No.	Question	Answer
1.	How old were you when you first began menstruating?	1. ____ years old
2.	What was the first day of your last menstrual period?	2. ____ month ____ day ____year
3.	Are you past your menopause, or have you had a hysterectomy?	3. ☐ Yes ☐ No
4.	If Yes: Have you noticed any vaginal bleeding since? **(Please skip to question 12)**	4. ☐ Yes ☐ No
5.	Was your last menstrual period normal?	5. ☐ Yes ☐ No
6.	How many days pass between the first day of each period?	6. ____ days pass
7.	How long do your periods last?	7. ____ days
8.	On your heaviest day, how many pads and/or tampons do you use?	8. ____ pads and/or ____ tampons at most
9.	Are your periods usually painful?	9. ☐ Yes ☐ No
10.	If Yes: Is the pain generally mild, moderate or severe?	10. ☐ Mild ☐ Moderate ☐ Severe pain
11.	How do you treat your pain?	11. Treat with ____________

GYNECOLOGY

No.	Question	Answer
12.	Do you examine your breasts at least once a month?	12. ☐ Yes ☐ No
13.	Have you noticed any discharge from your breasts?	13. ☐ Yes ☐ No
14.	Have you noticed any change in the size of your breasts?	14. ☐ Yes ☐ No
15.	Have you noticed any lumps or pain in your breasts?	15. ☐ Yes ☐ No
16.	Have you ever had a mammogram?	16. ☐ Yes ☐ No
17.	If Yes: Write in the month and year of your last test?	17. ____ month ____ year of last mammogram
18.	Have you had recurrent bladder infections?	18. ☐ Yes ☐ No
19.	Are you bothered by frequent or painful urination?	19. ☐ Yes ☐ No
20.	Do you have recurrent middle back pain?	20. ☐ Yes ☐ No
21.	Have you had any recent vaginal itching or discharge?	21. ☐ Yes ☐ No
22.	Have you ever had any infection in your tubes or ovaries?	22. ☐ Yes ☐ No
23.	Have you ever had a Pap test?	23. ☐ Yes ☐ No
24.	If Yes: Write in the month and year of your last test?	24. ____ month ____ year of last Pap test
25.	Have you ever had abnormal results from a Pap test?	25. ☐ Yes ☐ No
26.	Did your mother ever take DES or any other hormones when she was pregnant with you?	26. ☐ Yes ☐ No
27.	Are you currently having sexual intercourse?	27. ☐ Yes ☐ No
28.	If Yes: Do you have one or many partners?	28. ☐ One ☐ Many
29.	Do you have pain with sexual intercourse?	29. ☐ Yes ☐ No
30.	Do you use birth control on a regular basis?	30. ☐ Yes ☐ No
31.	What forms of birth control have you or your partner used?	31. ☐ Oral (type ____________) ☐ IUD ☐ Diaphragm ☐ Norplant ☐ Patcl ☐ Sponge ☐ Spermicide ☐ Condoms ☐ Other ____________
32.	Do you have any questions about birth control?	32. ☐ Yes ☐ No
33.	Have you ever had complications with any type of birth control?	33. ☐ Yes ☐ No
34.	Do you have any questions about sexually transmitted diseases?	34. ☐ Yes ☐ No
35.	Are there any questions or problems about sex that you would like to discuss?	35. ☐ Yes ☐ No
36.	Have you ever had any difficulty becoming pregnant?	36. ☐ Yes ☐ No

MEDICATIONS NOW TAKING

Are you now taking any of the following:

No.	Question	Answer
37.	Antibiotics	37. ☐ Yes ☐ No
38.	Penicillin	38. ☐ Yes ☐ No
39.	Sulfa Drugs	39. ☐ Yes ☐ No
40.	Aspirin	40. ☐ Yes ☐ No
41.	Codeine/Demerol/Other pain medicine	41. ☐ Yes ☐ No
42.	Sedatives/tranquilizers	42. ☐ Yes ☐ No
43.	Birth control pills	43. ☐ Yes ☐ No
44.	Estrogens	44. ☐ Yes ☐ No
45.	Other hormones	45. ☐ Yes ☐ No
46.	Blood pressure medicines	46. ☐ Yes ☐ No
47.	Other medicines/vitamins	47. ☐ Yes ☐ No
48.	Are you allergic to or do you react poorly to any medicines?	48. ☐ Yes ☐ No
49.	Are you a habitual user of any medicines or drugs?	49. ☐ Yes ☐ No

TURN TO THE BACK OF THIS PAGE →

PLEASE PRINT YOUR NAME IN THE SPACE TO THE RIGHT → Name ____________________

Section	Question	Answer
SUBSTANCE USE	50. Do you smoke cigarettes?	50. ❑ Yes ❑ No
	51. If Yes: How many packs per day do you smoke?	51. ____ packs per day
	52. Do you drink alcohol?	52. ❑ Yes ❑ No
	53. If Yes: What kind of alcohol do you consume?	53. ❑ Beer ❑ Wine ❑ Mixed drinks
	54. How much alcohol do you consume in a week?	54. ____ glasses per week
	55. How much caffeine do you consume in a typical day?	55. ❑ None ❑ 1-2 cups ❑ 3-4 cups ❑
	56. Do you take any street drugs?	56. ❑ Yes ❑ No
	57. If Yes: What type of street drugs do you use?	57. ______________ type of street dr
	58. How much do you use in a day?	58. ______________ amount per day
NUTRITION/EXERCISE	During an average day, do you consume the following:	
Serving Size in ( ).	59. 2-3 servings of milk(1C), yogurt(1C) and cheese(11/2-2 Oz)?	59. ❑ Yes ❑ No
C = cup	60. 6-9 servings of bread(1S), cereal(1 Oz), rice(1/2C) and pasta(1/2C)?	60. ❑ Yes ❑ No
Oz = ounce	61. 2-3 servings of fruit(1 med. fruit, 1/2C cooked/canned, 3/4C juice)?	61. ❑ Yes ❑ No
S = slice	62. 3-4 srvgs. of vegetables(1C raw leafy, 1/2C other cooked/raw, 3/4C juice)?	62. ❑ Yes ❑ No
T = tablespoon	63. 2 servings of meat or 5-6 Oz(2-3 Oz), poultry(2-3 Oz), fish(2-3 Oz), dry beans(1/2C=1 Oz), eggs(1=1 Oz) and nuts(2T=1 Oz) ?	63. ❑ Yes ❑ No
	64. Food supplements such as wheat germ, soy flakes, yeast bone meal?	64. ❑ Yes ❑ No
	65. Do you usually eat less than three meals a day?	65. ❑ Yes ❑ No
	66. In a year, how often do you diet?	66. ❑ Never ❑ 1-2 times ❑ 3-4 times ❑
	67. Are you currently on a diet?	67. ❑ Yes ❑ No
	68. Have you gained or lost weight recently?	68. ❑ Gained ❑ Lost weight
	69. If Yes: How many pounds?	69. ____ pounds
	70. Have you ever had an eating disorder?	70. ❑ Yes ❑ No
	71. If Yes: What was the eating disorder?	71. ❑ Anorexia ❑ Bulimia ❑ Pica
	72. Do you exercise on a regular basis?	72. ❑ Yes ❑ No
	73. If Yes: How many hours per week do you exercise?	73. ____ hours per week
	74. What type of exercise do you do?	74. ❑ Aerobics ❑ Running ❑ Walking ❑ Other (specify)____________
GENERAL SYSTEMS REVIEW	75. Do you have severe headaches more than once a week?	75. ❑ Yes ❑ No
	76. Have you noticed any unusual growth or loss of hair?	76. ❑ Yes ❑ No
	77. Are you bothered by sores or rashes on your skin?	77. ❑ Yes ❑ No
	78. Do you frequently have bruises on your body?	78. ❑ Yes ❑ No
	79. Are you frequently short of breath?	79. ❑ Yes ❑ No
	80. Have you ever coughed up blood?	80. ❑ Yes ❑ No
	81. Do you frequently have swollen hands, ankles, or feet (if not pregnant)?	81. ❑ Yes ❑ No
	82. Do you frequently have cramps in your legs at night (if not pregnant)?	82. ❑ Yes ❑ No
	83. Have you experienced any recent pains in your chest?	83. ❑ Yes ❑ No
	84. Have you noticed that your heart is beating irregularly or fairly rapidly?	84. ❑ Yes ❑ No
	85. Do you have frequent heartburn or indigestion?	85. ❑ Yes ❑ No
	86. Do you have frequent pain or discomfort in your stomach?	86. ❑ Yes ❑ No
	87. Are you frequently nauseated or sick to your stomach?	87. ❑ Yes ❑ No
	88. Do you suffer from recurrent diarrhea or constipation?	88. ❑ Yes ❑ No
	89. Have you noticed any blood in your stools?	89. ❑ Yes ❑ No
	90. Have your stools been black or tarry?	90. ❑ Yes ❑ No
	91. Are you bothered by frequent aching or stiffness in your joints?	91. ❑ Yes ❑ No
	92. Do you suffer from frequent pain in your legs or feet?	92. ❑ Yes ❑ No
	93. Are you bothered by frequent aches or pains in your lower back?	93. ❑ Yes ❑ No
	94. Have you gotten dizzy or fainted recently?	94. ❑ Yes ❑ No
	95. Have you noticed frequent numbness in your hands or in your feet?	95. ❑ Yes ❑ No
	96. Do you have seizures or convulsions?	96. ❑ Yes ❑ No
	97. Do you feel nervous most of the time?	97. ❑ Yes ❑ No
	98. Do you usually feel lonely or depressed?	98. ❑ Yes ❑ No
	99. Do you frequently have trouble sleeping?	99. ❑ Yes ❑ No
	100. Do you have frequent nightmares?	100. ❑ Yes ❑ No
	101. Are you concerned about any work or family problems?	101. ❑ Yes ❑ No
	102. Are you constantly tired?	102. ❑ Yes ❑ No

USE THE SPACE TO THE RIGHT TO COMMENT ON ANY OF YOUR ANSWERS, OR TO DESCRIBE ANY SPECIAL PROBLEMS YOU MIGHT HAVE.

END

Systems for Improved Healthcare
milcom
A Division of Briggs Corporation

Initial Gynecology Profile

Patient's Name: ____________________

ID No.: ____________________

INITIAL PHYSICAL EXAM

1. Height ____________________
2. Weight ____________________
3. Blood Pressure ____________________

Pelvic Exam	Normal	Abn.	N.E.
4. Ext. Genitalia			
5. Urethral Meatus			
6. Urethra			
7. Bladder			
8. Vagina			
9. Cervix			
10. Uterus (describe)			
11. Adnexa/Parametria			
12. Rectum (Digital Exam)			
13. Anus and Perineum			
14. Other			

General Physical	Normal	Abn.	N.E.
15. Skin			
16. HEENT			
17. Neck			
18. Chest			
19. Breasts	/		
20. Heart			
21. Lungs			
22. Abdomen			
23. Musculoskeletal			
24. Extremities			
25. Neurological			

N.E. = Not Evaluated

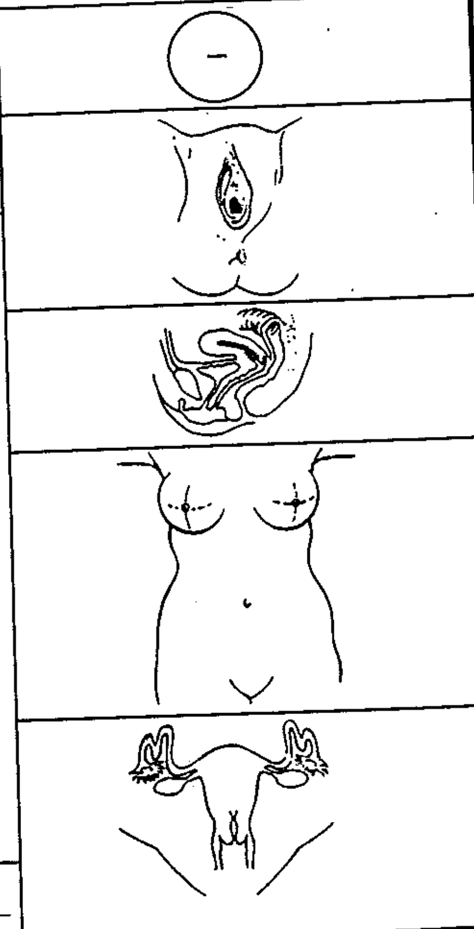
Nutritional Assessment

26. Not performed .... ☐
27. Apparently adequate .... ☐
28. Apparently inadequate .... ☐
29. Excessive caloric intake .... ☐

Check and detail all positive findings below.
Use system numbers.

LABORATORY PROCEDURES

Test	Date	Result
30. Hgb	/	
31. Hct	/	
32. WBC	/	
33. Differential	/	
34. Pregnancy Test	/	
35. Urinalysis	/	
36. HIV	/	
37. Gonorrhea	/	
38. Chlamydia	/	
39. HSV	/	
40. VDRL Serology	/	
41. Hepatitis ___	/	
42. Pap Test	/	
43. Wet Mount	/	
44. Culture	/	
45. Stool Occult Blood	/	
46. Blood Glucose	/	
47. Cholesterol	/	
48. Thyroid Screen	/	
49. Biopsy	/	
50. Mammogram	/	
51.	/	
52.	/	
53.	/	
54.	/	



Diagnosis and Treatment Plans

Next Appointment: ___ /___ /___ Signature: ____________________