

## COMPREHENSIVE GYNECOLOGICAL HISTORY & PHYSICAL

DATE OF VISIT

NAME WT. HT. BLOOD PRESSURE

DATE OF BIRTH AGE REFERRED BY

**REASON FOR VISIT:**


### MENSTRUAL/MENOPAUSAL HISTORY

LAST PERIOD: / / LAST PAP SMEAR: / / HISTORY OF ABNORMAL PAP SMEARS:  YES  NO

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MAMMOGRAM: / / BONE DENSITY: / /

**CONTRACEPTION** CURRENT: PAST:

**OBSTETRICAL RECORD:      G      P**

DELIVERY DATE	MISCARRIAGE	MONTH PREMATURE	STILL-BORN	PREGNANCY COMPLICATED	C/SECTION	MULTIPLE	MONTHS BREAST FED	WEIGHT AT BIRTH	SEX

### PAST MEDICAL HISTORY

PERSONAL	FAMILY	ANY OTHER ILLNESS?
<input type="checkbox"/> HEADACHES/MIGRAINE	<input type="checkbox"/>	
<input type="checkbox"/> EENT		
<input type="checkbox"/> HYPERTENSION	<input type="checkbox"/>	
<input type="checkbox"/> RESPIRATORY PROBLEMS		
<input type="checkbox"/> BREAST DISEASE	<input type="checkbox"/>	
<input type="checkbox"/> JAUNDICE/HEPATITIS		
<input type="checkbox"/> GALL BLADDER DISEASE		
<input type="checkbox"/> HIATAL HERNIA/PEPTIC ULCER		
<input type="checkbox"/> BOWEL DISORDERS		
<input type="checkbox"/> KIDNEY PROBLEMS	<input type="checkbox"/>	
<input type="checkbox"/> URINARY TRACT PROBLEMS		
<input type="checkbox"/> ANEMIA/BLOOD DISORDERS	<input type="checkbox"/>	
<input type="checkbox"/> BLOOD TRANSFUSIONS		
<input type="checkbox"/> VARICOSE VEINS/PHLEBITIS	<input type="checkbox"/>	
<input type="checkbox"/> DIABETES	<input type="checkbox"/>	
<input type="checkbox"/> THYROID DISEASE	<input type="checkbox"/>	
<input type="checkbox"/> CANCER	<input type="checkbox"/>	
<input type="checkbox"/> EPILEPSY/NEUROL DISORD.	<input type="checkbox"/>	
<input type="checkbox"/> SMOKING _____ CIG/DAY		
<input type="checkbox"/> ALCOHOL _____ OZ/WK		

### SURGERIES/HOSPITALIZATIONS

MO/YR	ILLNESS/OPERATIONS	MO/YR	ILLNESS/OPERATION

**CURRENT MEDICATIONS**

**DRUG ALLERGIES**

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PATIENT'S NAME: \_\_\_\_\_

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

Thyroid \_\_\_\_\_

Heart \_\_\_\_\_ Lungs \_\_\_\_\_ Liver \_\_\_\_\_ Spleen \_\_\_\_\_

Abdomen \_\_\_\_\_

Breasts: Secreting \_\_\_\_\_ Painful \_\_\_\_\_ Distended \_\_\_\_\_ Skin Reddened \_\_\_\_\_

Nipples: Cracked \_\_\_\_\_ Erect \_\_\_\_\_ Flat \_\_\_\_\_ Inverted \_\_\_\_\_

Lower extremities \_\_\_\_\_

Perineum Firm \_\_\_\_\_ Lacerated \_\_\_\_\_ Anus: Hemorrhoids \_\_\_\_\_ Fissure \_\_\_\_\_

Vulva: urethral orifice, inflamed \_\_\_\_\_ Relaxed \_\_\_\_\_ Leakage \_\_\_\_\_

Vagina: Secretion \_\_\_\_\_ Relaxed \_\_\_\_\_ Cystocele \_\_\_\_\_ Rectocele \_\_\_\_\_

Cervix: Length \_\_\_\_\_ Thickness \_\_\_\_\_ Lacerations \_\_\_\_\_ Endocervicitis \_\_\_\_\_

Uterus: Position \_\_\_\_\_ Mobility \_\_\_\_\_ Consistency \_\_\_\_\_

\_\_\_\_\_ Size \_\_\_\_\_ Tumors \_\_\_\_\_

Right Adnexa \_\_\_\_\_ Left Adnexa \_\_\_\_\_

Utero-sacral ligaments \_\_\_\_\_

Rectal: \_\_\_\_\_

Remarks: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Laboratory: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Assessment: \_\_\_\_\_

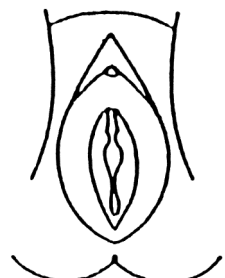
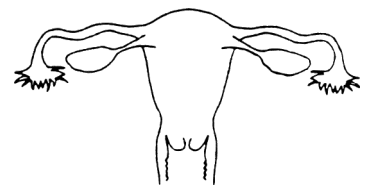
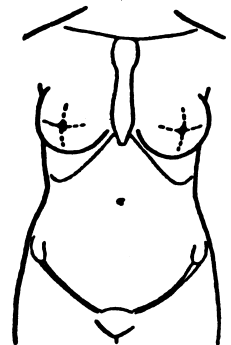
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Treatment Plan/Recommendations: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



EXT. GENITALIA