

NAME: _____

Date of Birth: _____

Date of Visit: _____

MEDICAL HISTORY

Who referred you for Consultation? _____ His / Her Specialty: _____

Referring Dr.'s Address: _____ Phone # () _____

Are there any other physicians (e.g. Primary Care) with whom you would like your consultation discussed?

Dr.'s Name & Address: _____ Specialty: _____

_____ Phone # () _____

For what reason were you referred?

Please Circle any symptoms and check any problems body system problems you have :

Excessive Weight gain or loss Fever/Chills/Night sweats Loss of appetite Fatigue/Malaise

Chest pain /Palpitations Problems with urination Nausea/Vomiting/heartburn/Change in bowel habit

Cough /Shortness of breath/Other Respiratory probs: _____ Allergy or Immune problems: _____

Dizziness/Fainting/Headache/ Other Neurologic probs: _____ Psychological problems: _____

Vaginal bleeding/discharge/Menstrual probs: _____

Problems with: Skin Eyes/Ears/Nose/Throat Blood/Lymph system Muscles Endocrine (glands)
(Explain:) _____

Name: _____

PAST MEDICAL HISTORY Please check any medical problems with which you have ever been diagnosed:

- | | |
|--|--|
| <input type="checkbox"/> Hypertension (High blood Pressure) | <input type="checkbox"/> Hemophilia or other Bleeding disorder |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Phlebitis / Blood clots in deep veins or lung |
| <input type="checkbox"/> Heart problems | <input type="checkbox"/> Lung Problems |
| <input type="checkbox"/> Coronary Artery Disease /Heart Attack | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Hypercholesterolemia (High Cholesterol) | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Arrhythmia (Irregular hear beat) | |
| <input type="checkbox"/> Liver problems | <input type="checkbox"/> Kidney / Bladder problems: |
| <input type="checkbox"/> Hepatitis: ___A ___B ___C | <input type="checkbox"/> Stones |
| <input type="checkbox"/> Gall Bladder attacks | <input type="checkbox"/> Infection |
| <input type="checkbox"/> Neurologic/Psychiatric problems | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Hypothyroidism (Low Thyroid) |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Hyperthyroidism (Overactive) |
| <input type="checkbox"/> Depression | |
| <input type="checkbox"/> Stomach problems | <input type="checkbox"/> Cancer: Type _____ |
| <input type="checkbox"/> Ulcer | <input type="checkbox"/> Received Radiation |
| <input type="checkbox"/> Acid reflux | <input type="checkbox"/> Received Chemotherapy |

Other: _____

Have you ever had a flexible sigmoidoscopy or colonoscopy (screening for colon cancer)? _____ When? _____

Any other medical problems, injuries or hospitalizations? _____

List all the Medications you take – including the dose and frequency: _____

Are you allergic to any medications or Latex? _____ If so, what type of reaction? _____

List all of the Surgeries you've had and the dates: _____

Name: _____

OBSTETRIC & GYNECOLOGIC HISTORY

Age at first menstrual period? _____ Are they (or were they) regular or irregular? _____

Date of last period: _____ How long are/were they? _____ How many days between periods? _____

Number of pregnancies: _____ # of births: _____ # of Abortions: _____ # of Miscarriages: _____

Vaginal deliveries: _____ Cesarean Sections: _____ Reason for C-Section: _____

When was your last Pap Smear? _____ Pap before that? _____ Any abnormal Paps? _____

When was your last mammogram? _____ Any abnormal? _____ Any biopsies? _____

Did you ever take the birth control pill? _____ For how many years in total? _____

Ever taken hormone replacement therapy (Estrogen and/or progesterone)? _____ How long? _____

Type of hormone therapy and how taken: _____

Have you ever had sex ? _____ With? (circle) Men / Women / Both Any problems? _____

Are you currently sexually active? _____ Do you have pain with intercourse? _____

Do you use birth control? _____ What method? _____ Have you ever used an IUD? _____

Have you had any gynecologic problems in the past? _____ (*Check all that apply*)

_____ Fibroids _____ Ovarian cysts _____ Endometriosis _____ Infertility _____ PMS

_____ Sexually transmitted diseases (Herpes, HPV, Chlamydia, Gonorrhea, Syphilis, HIV) or PID

_____ Heavy bleeding requiring medication or surgery _____ Pelvic prolapse or urinary problems

FAMILY HISTORY

Does anyone in your family have cancer? (Who & what type) _____

Any other serious medical problems run in your family? (Explain) _____

SOCIAL HISTORY

_____ Single _____ Married- how long? _____ _____ Divorced _____ Domestic partnered _____ Widowed

Education level achieved _____ Do you work outside the home? _____ What type of work? _____

Where do you live? _____ Who lives with you at home? _____

On whom do you rely for emotional support or help with decisions? _____ Relationship: _____

Do you smoke? _____ Did you use to smoke? _____ How many packs per day? _____ How long? _____

How much alcohol do you drink? _____ None _____ Minimal _____ Moderate _____ Excessive

Any other information you think may be helpful? (Explain) _____

NAME: _____

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PHYSICAL EXAM

VS: BP = / HR= RR= T= Ht: Wt: BMI:

(FINDINGS ARE WNL UNLESS INDICATED OTHERWISE)

HEENT:

Neck:

LN: Cervical
Axillary
Inguinal
Supraclavicular

Breasts: _____ Deferred (post recent exam)

Back:

Lungs:

Cor:

Abdomen:

Neuro/Psych:

Extrem:

PELVIC: Ext gen:

Cervix:

Vagina:

Uterus:

Urethra/Bladder:

Adnexa/RVE:

Stool guaiac:

IMPRESSION /PLAN: