

Name \_\_\_\_\_ DOB \_\_\_\_\_ Doctor's Name \_\_\_\_\_

**CHIEF COMPLAINT** \_\_\_\_\_

**HPI**

- |   |  |
|---|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N Contraception           | <input type="checkbox"/> Y <input type="checkbox"/> N Menorrhagia (excessive/frequent periods)   |
| <input type="checkbox"/> Y No Symptoms  | <input type="checkbox"/> Y <input type="checkbox"/> N Bleeding between periods                   |
| <input type="checkbox"/> Y <input type="checkbox"/> N Fatigue                 | <input type="checkbox"/> Y <input type="checkbox"/> N Dysmenorrhea (painful periods)             |
| <input type="checkbox"/> Y <input type="checkbox"/> N Headache                | <input type="checkbox"/> Y <input type="checkbox"/> N Metrorrhagia (bleeding unrelated to cycle) |
| <input type="checkbox"/> Y <input type="checkbox"/> N Breast symptoms         | <input type="checkbox"/> Y <input type="checkbox"/> N Light bleeding between periods             |
| <input type="checkbox"/> Y <input type="checkbox"/> N Abdominal pain          | <input type="checkbox"/> Y <input type="checkbox"/> N Vaginal discharge                          |
| <input type="checkbox"/> Y <input type="checkbox"/> N Female Genital symptoms | <input type="checkbox"/> Y <input type="checkbox"/> N Anxiety                                    |
| <input type="checkbox"/> Y <input type="checkbox"/> N Hot flashes             | <input type="checkbox"/> Y <input type="checkbox"/> N Depression                                 |
| <input type="checkbox"/> Y <input type="checkbox"/> N Pelvic pain             |  |
- 

**PMH**

**Previous History**

- Y  N History of Cervical Dysplasia (abnormal cells)
- Y  N History of Human Papilloma Virus
- Y  N History of Menopause
- Y  N History of UTI ( urinary tract infection)

**LMP, Contraception, and Sexual History**

- Y  N \_\_\_\_\_ last menstrual period
- Y  N Contraception
- Y  N Sexually active
- Y  N \_\_\_\_\_ last Pap Smear

**Social History**

- Y  N Alcohol, if yes how much \_\_\_\_\_
- Y  N Tobacco, if yes how much \_\_\_\_\_
- Y  N Drug use

**Pregnancy Summary**

- Y \_\_\_\_\_ Gravida (how many times pregnant)
- Y \_\_\_\_\_ Para (how many live children)
- Y \_\_\_\_\_ Aborta (miscarriage/elective abortions)

**Family History**

- Y  N FH of Breast Cancer
- Y  N FH of Diabetes Mellitus
- Y  N Down Syndrome
- Y  N FH of HTN (high blood pressure)
- Y  N Tay-Sachs Gene
- Y  N FH of Colon Cancer

**Prev. Surgical Procedures & Dates** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Current Medications** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Drug Allergies** \_\_\_\_\_

**PMH - Medical**

- |  |   |
|--|---|
| <input type="checkbox"/> Y <input type="checkbox"/> N History of Allergic Rhinitis                 | <input type="checkbox"/> Y <input type="checkbox"/> N History of Hyperthyroidism                |
| <input type="checkbox"/> Y <input type="checkbox"/> N History of Asthma                            | <input type="checkbox"/> Y <input type="checkbox"/> N History of Hypothyroidism                 |
| <input type="checkbox"/> Y <input type="checkbox"/> N History of Acute Bronchitis                  | <input type="checkbox"/> Y <input type="checkbox"/> N History of Breast Cancer                  |
| <input type="checkbox"/> Y <input type="checkbox"/> N History of CAD (heart disease)               | <input type="checkbox"/> Y <input type="checkbox"/> N History of Hepatitis                      |
| <input type="checkbox"/> Y <input type="checkbox"/> N History of CHF (heart failure)               | <input type="checkbox"/> Y <input type="checkbox"/> N History of Lumbago (back pain)            |
| <input type="checkbox"/> Y <input type="checkbox"/> N History of COPD                              | <input type="checkbox"/> Y <input type="checkbox"/> N History of Obesity                        |
| <input type="checkbox"/> Y <input type="checkbox"/> N History of DM Type II                        | <input type="checkbox"/> Y <input type="checkbox"/> N History of Osteoarthritis (joints)        |
| <input type="checkbox"/> Y <input type="checkbox"/> N Esophagitis Chronic Reflux                   | <input type="checkbox"/> Y <input type="checkbox"/> N History of PYELO (inflammation of kidney) |
| <input type="checkbox"/> Y <input type="checkbox"/> N History of Essential Hypertension            | <input type="checkbox"/> Y <input type="checkbox"/> N History of Renal Failure                  |
| <input type="checkbox"/> Y <input type="checkbox"/> N History of Hyperlipidemia (high cholesterol) | <input type="checkbox"/> Y <input type="checkbox"/> N History of Stroke Syndrome (CVA)          |

**ROS**

**Systemic symptoms**

- Y  N Weight change
- Y  N Chills

**Breast symptoms**

- Y  N Breast pain
- Y  N Nipple discharge

- Y  N Fever
- Y  N Night sweats
- Y  N Feeling tired or poorly (malaise)
- Y Other Constitutional symptoms

#### Head symptoms

- Y  N Headache
- Y  N Facial pain
- Y  N Sinus pain
- Y Other Head-related symptoms

#### Otolaryngeal symptoms

- Y  N Earache
- Y  N Hearing loss
- Y  N Ringing in the ears
- Y  N Nosebleeds (epistaxis)
- Y  N Nasal discharge
- Y  N Mouth sores
- Y  N Bleeding gums
- Y  N Hoarseness
- Y  N Throat pain
- Y Other Otolaryngeal symptoms

#### Cardiovascular symptoms

- Y  N Chest pain or discomfort
- Y  N Fast heart rate
- Y  N Palpitations
- Y Other Cardiovascular symptoms

#### Neurological symptoms

- Y  N Dizziness
- Y  N Vertigo
- Y  N Fainting (syncope)
- Y  N Motor disturbances
- Y  N Sensory disturbances
- Y Other Neurological symptoms

#### Endocrine symptoms

- Y  N Excessive sweating
- Y  N Excessive thirst (polydipsia)
- Y  N Libido has changed (sex drive)
- Y Other Endocrine symptoms

#### PMH - Psychiatric

- Y History of Anxiety Disorder
- Y History of Depression

- Y  N Breast lump
- Y Other Breast symptoms

#### Skin symptoms

- Y  N Pruritus (itching)
- Y  N Skin lesions
- Y  N Rashes
- Y Other Skin symptoms

#### Gastrointestinal symptoms

- Y  N Appetite
- Y  N Difficulty swallowing (dysphagia)
- Y  N Heartburn
- Y  N Nausea
- Y  N Vomiting
- Y  N Abdominal pain
- Y  N Diarrhea
- Y  N Black or bloody stools
- Y Other Gastrointestinal symptoms

#### Pulmonary symptoms

- Y  N Shortness of breath
- Y  N Cough
- Y  N Coughing up blood (hemoptysis)
- Y  N Night sweats

#### Genitourinary symptoms

- Y  N Dysuria
- Y  N Increased urinary frequency
- Y  N Hematuria (blood in urine)
- Y  N Genital lesion
- Y Other Genitourinary symptoms

#### Psychological symptoms

- Y  N Sleep disturbances
- Y  N Anxiety
- Y  N Depression
- Y Other Psychological symptoms