Date of Service / / **Time of Service : ❒ AM ❒ PM**

Is this a consultation? ❒Yes ❒No If yes, name and address of requesting physician

IMPORTANT REMINDER: Consultations include a written reply to the requesting physician!

CHIEF COMPLAINT (CC)--Reason for patient's visit today

HISTORY - COMPLETED BY PROVIDER

DOCUMENT History of Present Illness *(Location, Quality, Severity, Duration, Timing, Context, Modifying Factors, Associated signs/symptoms)*
OR Status of Chronic or Inactive Conditions *(3 or more = extended w/o HPI)* *(1-3 brief, 4+ extended)*

GYNECOLOGIC HISTORY

Last Menstrual Period______________________ (mm/dd/yyyy)
Menarche___________
Cycle__________ (days)
Length_________(days)
Contraception___________________________________
Hormone Replacement Therapy___________________

YES	NO	
❒	❒	Endometriosis
❒	❒	Infertility
❒	❒	Ovarian Cysts
❒	❒	Pelvic Cysts
❒	❒	Uterine Leiomyoma (Fibroids)

Sexually Transmitted Diseases

OBSTETRICAL HISTORY

Gravidity_____ Parity Term_____ Preterm_____ Abortion_____ Ectopic_____ Living_____

#	Date	M/F	Weight	G.A.	Mode of Delivery	Anesthesia	Time	Complications
1								
2								
3								
4								
5								
6								
7								

OB Comments

PREVENTIVE CARE

	PAP SMEARS	COLPOSCOPY	MAMMOGRAM	BONE DENSITY	COLONOSCOPY	GUAIAC
Date						
Results						

FAMILY AND SOCIAL HISTORY

What is the Health Status of the Patient's Family?
Mother:_______________________ Father:_______________________
Grandparents:_______________________ Brothers/Sisters:_______________________
Family Illnesses:
History of Heart Disease (heart attack, heart failure) ❒ yes ❒ no
History of strokes? ❒ yes ❒ no History of high blood pressure? ❒ yes ❒ no History of diabetes? ❒ yes ❒ no

What is patient's Social History? Marital Status (circle one): Divorced Domestic Partnered Married Single Widowed
Who lives with the patient?________________ Current Employer________________ Patient's Occupation________________
Does patient smoke?_____ Cigarettes_____ (# of packs/day) Cigars_____ (# of cigars/day) Pipe_____ (# of bowls/day) For how many years?_________
Does patient drink alcohol?_____ How many drinks? __________per day __________per week __________per month
Does patient use illicit drugs?__________ If yes, what kind?________________ How often?________________
Is patient sexually active? ❒ Yes ❒ No Does patient use condoms? (circle one) Always Sometimes Never
Other contraceptive use? ❒ Yes ❒ No If yes, what kind?________________
Other high risk behavior? ❒ Yes ❒ No If yes, describe

Date of Service / /

❒ **See Patient Health Questionnaire dated _______________ (mm/dd/yyyy) for additional ROS and PFSH.**

Is the patient having any current problems, signs, or symptoms in any of the following areas? (Provider *MUST* comment on all "Yes" responses.)

YES	NO		YES	NO	
❒	❒	Constitutional	❒	❒	Integumentary (Skin and Breast)
❒	❒	Eyes	❒	❒	Neurological
❒	❒	Ears, Nose, Throat	❒	❒	Psychiatric
❒	❒	Cardiovascular	❒	❒	Endocrine
❒	❒	Respiratory	❒	❒	Hematologic/Lymphatic
❒	❒	Gastrointestinal	❒	❒	Allergy/Immunology
❒	❒	Genitourinary	❒	❒	Other ________________________
❒	❒	Musculoskeletal	❒	❒	Other

Medications (prescription, O-T-C, vitamins, herbals--include oral, eye drops, ear drops, nose drops, suppositories, skin lotions and creams used on a *regular* basis)

Allergies

REVIEW OF SYSTEMS (ROS)/PAST MEDICAL HISTORY

Provider Comments - Review of systems

PAIN EVALUATION: **Is patient experiencing pain?** ❒ **YES** ❒ **NO**
Duration_______________
Pain severity, per patient_____0-10
Is pain acceptable to patient? ❒ **YES** ❒ **NO**

❒ All other systems reviewed & negative

Review of Systems *: 1 problem pertinent, 2-9 extended, 10+ complete*

Has patient had Chicken Pox? ❒ Yes ❒ No Has patient had PPD Testing? ❒ Yes ❒ No Date of last PPD_______________

Previous Surgeries/Hospitalizations--Dates:

Past Medical History

COUNSELING AND COORDINATION OF CARE

❒ **When this box is checked, more than fifty percent (50%) of this service was time spent counseling the patient and/or coordinating patient care.**
Total Time of Visit __________ Time Spent in Counseling __________
Details of counseling and/or coordination of care MUST be documented!

EXAM

Height	Weight	Temperature	BP Right Arm Sitting	Right Arm Standing	Left Arm Standing	Left Arm Sitting	Pulse (BPM)	Respiration

PHYSICAL EXAMINATION

			COMMENTS
Constitutional	❒ **Normal**	❒ **Abnormal**	
Psychiatric (Alert/Oriented X 3)	❒ **Normal**	❒ **Abnormal**	
Neurologic	❒ **Normal**	❒ **Abnormal**	
Dermatologic	❒ **Normal**	❒ **Abnormal**	

Date of Service / /

PHYSICAL EXAMINATION

HEENT	❒ Normal	❒ Abnormal	
Neck/Thyroid	❒ Normal	❒ Abnormal	
Cardiac (RRR)	❒ Normal	❒ Abnormal	
Pulmonary (CTA)	❒ Normal	❒ Abnormal	
Liver/Spleen	❒ Normal	❒ Abnormal	
Abdomen	❒ Normal	❒ Abnormal	
Back/Hernia	❒ Normal	❒ Abnormal	
Extremities	❒ Normal	❒ Abnormal	

BREAST EXAMINATION

YES	NO		COMMENTS
❒	❒	Symmetrical	
❒	❒	Dominant Masses	
❒	❒	Tenderness	
❒	❒	Lymphadenopathy	

PELVIC EXAMINATION

			COMMENTS
External Genitalia	❒ Normal	❒ Abnormal	
Urethra	❒ Normal	❒ Abnormal	
Bladder	❒ Normal	❒ Abnormal	
Vagina	❒ Normal	❒ Abnormal	
Cervix	❒ Normal	❒ Abnormal	
Rectovaginal	❒ Normal	❒ Abnormal	
Uterus Normal size	❒ Normal	❒ Abnormal	
Uterus Normal shape	❒ Normal	❒ Abnormal	
Uterus mobile	❒ Normal	❒ Abnormal	
Uterus Non-tender	❒ Normal	❒ Abnormal	
Adnexa Non-tender	❒ Normal	❒ Abnormal	
Adnexa No Unusual Masses	❒ Normal	❒ Abnormal	

Date of Service / /

IMPRESSION

NORMAL GYNECOLOGICAL EXAMINATION________________________________

OTHER DIAGNOSES________________________________

____

____

PLAN

TESTS ORDERED/SUGGESTED

- ❒ CBC
- ❒ Chlamydia Trachomatis
- ❒ Colposcopy
- ❒ Free T4
- ❒ HBsAg
- ❒ Hepatitis Panel
- ❒ HIV
- ❒ Lipid Panel
- ❒ Liver Enzymes (SGOT, SGPT, LDH)
- ❒ Neisseria Gonorrhea
- ❒ Pap Smear
- ❒ PPD
- ❒ TSH (Thyroid Stimulating Hormone)
- ❒ Other________________

COUNSELING PERFORMED/EDUCATIONAL MATERIALS PROVIDED

- ❒ Breast Self-Examination
- ❒ Calcium
- ❒ Contraception
- ❒ Diet/Weight Control
- ❒ Hormone Replacement Therapy
- ❒ Preconception
- ❒ Smoking Cessation
- ❒ STD/PID/HIV
- ❒ Other________________
- ❒ Other________________

WET PREP

- ❒ Normal
- ❒ Trichomoniasis
- ❒ Clue Cells
- ❒ Hyphae
- ❒ Leukocytosis

New Meds________________________________

____

____

Refilled Meds________________________________

____

____

❒ Reviewed risks/benefits of Oral Contraceptive Pills (OCPs)________________________________

❒ Reviewed risks/benefits of Hormone Replacement Therapy (HRT) ________________________________

Treatment Ordered/Suggested________________________________

____

____

____

Consultations Ordered/Suggested________________________________

____

____

____

FOLLOW-UP

❒ PATIENT TO RETURN: ❒ in __________days ❒ in __________weeks ❒ in _________months ❒ in one year ❒ prn

RESIDENT'S/FELLOW'S SIGNATURE (include credentials, i.e., M.D., D.O., and PGY status)	DATE	TIME
		❒ AM ❒ PM

TEACHING PHYSICIAN DOCUMENTATION Additional documentation of teaching physician:

Physicians at Teaching Hospitals (PATH) Statements--Check *ONLY* ONE BOX, and fill in the name of the appropriate resident/fellow:

A. ❒ I was present with Dr. ____________________ (Name of Resident/Fellow) during the history and exam. I discussed the case with the resident/fellow and agree with the findings and plan as documented in the resident's/fellow's note except as noted.

B. ❒ I saw and evaluated the patient. I discussed the case with Dr. ____________________ (Name of Resident/Fellow) and agree with the resident's/fellow/s findings and plan as documented in the resident's/fellow's note except as noted.

PROVIDER'S SIGNATURE (include credentials, i.e., M.D., D.O.)	DATE	TIME
		❒ AM ❒ PM

PROVIDER'S SIGNATURE--LATE ENTRY (if applicable) (include credentials, i.e., M.D., D.O.)	DATE	TIME
		❒ AM ❒ PM