

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)

Contraception \_\_\_\_\_

Hormone Replacement Therapy \_\_\_\_\_

REVIEW OF SYSTEMS (ROS)/PAST MEDICAL, FAMILY, AND SOCIAL HISTORY (PFSH)

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                       |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>        | <input type="checkbox"/> |
| Constitutional           |                          | Integumentary (Skin and Breast) |                          |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>        | <input type="checkbox"/> |
| Eyes                     |                          | Neurological                    |                          |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>        | <input type="checkbox"/> |
| Ears, Nose, Throat       |                          | Psychiatric                     |                          |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>        | <input type="checkbox"/> |
| Cardiovascular           |                          | Endocrine                       |                          |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>        | <input type="checkbox"/> |
| Respiratory              |                          | Hematologic/Lymphatic           |                          |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>        | <input type="checkbox"/> |
| Gastrointestinal         |                          | Allergy/Immunology              |                          |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>        | <input type="checkbox"/> |
| Genitourinary            |                          | Other _____                     |                          |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>        | <input type="checkbox"/> |
| Musculoskeletal          |                          | Other _____                     |                          |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>        | <input type="checkbox"/> |

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

Allergies

Previous Surgeries/Hospitalizations--Dates:

Past Medical 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 \_\_\_\_\_

EXAM

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!

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

(Patient Name, Medical Record Number,

Date of Birth, Date of Service, **Time of Service\***, Patient Gender)

GYNECOLOGIC EXAMINATION

Department of OB/GYN

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Revised Form 07/2006

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EXAM, continued

PHYSICAL EXAMINATION

WET PREP

- Normal
- Clue Cells
- Leukocytosis
- Trichomoniasis
- Hyphae

IMPRESSION

NORMAL GYNECOLOGICAL EXAMINATION \_\_\_\_\_

OTHER DIAGNOSES \_\_\_\_\_

PLAN

TESTS ORDERED/SUGGESTED

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Pap Smear             | <input type="checkbox"/> Colonoscopy                     | <input type="checkbox"/> HBsAg           |
| <input type="checkbox"/> Colposcopy            | <input type="checkbox"/> CBC                             | <input type="checkbox"/> Hepatitis Panel |
| <input type="checkbox"/> Neisseria Gonorrhea   | <input type="checkbox"/> Lipid Panel                     | <input type="checkbox"/> PPD             |
| <input type="checkbox"/> Chlamydia Trachomatis | <input type="checkbox"/> Liver Enzymes (SGOT, SGPT, LDH) | <input type="checkbox"/> TSH             |
| <input type="checkbox"/> Mammogram             | <input type="checkbox"/> VDRL/RPR                        | <input type="checkbox"/> Free T4         |
| <input type="checkbox"/> Bone Density          | <input type="checkbox"/> HIV                             | <input type="checkbox"/> Other _____     |

New Meds \_\_\_\_\_

Refilled Meds \_\_\_\_\_

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

Treatment Ordered/Suggested \_\_\_\_\_

Consultations Ordered/Suggested \_\_\_\_\_

FOLLOW-UP

PATIENT TO RETURN:  in \_\_\_\_\_ days  in \_\_\_\_\_ weeks  in \_\_\_\_\_ months  in one year  prn

RESIDENT PARTICIPATION?  Yes  No  When this box is checked, the resident/fellow signing below makes the following attestation: "I attest that I saw and examined this patient, and that Dr. \_\_\_\_\_ was physically present for the key portions of the service provided/entire service provided (circle one)."

RESIDENT'S/FELLOW'S SIGNATURE \_\_\_\_\_

DATE/TIME \_\_\_\_\_

TEACHING PHYSICIAN DOCUMENTATION

Additional documentation of teaching physician:

When this box is checked, the provider signing below makes the following attestation(s) (check all that apply):

- I saw and examined this patient.
- I was physically present for the key portions of the service provided to the patient by the resident/fellow.
- I was physically present for the entire service provided to the patient by the resident/fellow.
- I have discussed this case with the resident/fellow.
- I reviewed the documentation of the resident/fellow.
- I agree with the resident's/fellow's documentation except as noted above.

PROVIDER'S SIGNATURE \_\_\_\_\_

DATE/TIME \_\_\_\_\_

PATIENT IDENTIFICATION  
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GYNECOLOGIC EXAMINATION  
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