WILLIAMS, BENAVIDES, MARSTON & KAMINSKI MD, PA

GYNECOLOGIC ASSESSMENT

Chart # ________________

Patient's Name: ____ Date: ___________ Age: ________

Chief Complaint/ Please describe any problems that you want to discuss today: ______________________________

____

____

PAST MEDICAL HISTORY

1. How many pregnancies have you had? *(Circle one)* 0 1 2 3 4 5 6 7 8 9 10

   How many full-term? Full term _____ Miscarriages _____ Abortions _____ Stillborns _____ Living Children Now _____

2. Have you had any new health problems or surgery this year? YES NO

   If so, please describe: ____

   ____

3. Are you seeing another physician on a regular basis? YES NO

   If so, which physician and for what problem? ____

   ____

4. Please list all medications you are currently taking along with doses: ___________________________

   ____

   ____

5. Are you allergic to any medications, latex, or betadine? YES NO

   If so, please list:____

6. Date of last menstrual period: __________________

   a. Any pain with your periods? YES NO
   b. Any bleeding between periods? YES NO
   c. Are periods regular? YES NO
   c. Is flow normal? YES NO

7. What birth control method do you use, if any? ____

FAMILY / SOCIAL HISTORY

1. Has there been any change in your family's medical history this year? YES NO

   If so, please describe: ____

2. Do you smoke? YES NO
3. Do you drink alcohol on a regular basis? YES NO
4. Do you use illegal drugs? YES NO
5. Are you or any member of your family in an abusive situation? YES NO

HEALTH MAINTENANCE

1. Have you ever had a mammogram? What year? Year _______ Never had
2. Have you ever had a bone density study? Year _______ Never had
3. Have you ever had your cholesterol checked? Year _______ WNL ELEVATED

REVIEW OF SYSTEMS Please CIRCLE if you CURRENTLY have any of the following:

1. ***General Symptoms:*** Unexplained fevers, sweats, problems sleeping, eating disorder such as decrease appetite, marked weight change
2. ***Skin:*** Change in any moles, new moles, any new skin lesions or rash
3. ***Eyes:*** Change in vision, glasses/contacts?
4. ***Breasts:*** Discharge, pain, lump
5. ***Respiratory System:*** Unexplained cough, change in sputum, asthma, wheezing, coughing up blood
6. ***Cardiovascular System:*** Irregular heart beats, chest pain, shortness of breath
7. ***Gastrointestinal Tract:*** Nausea and vomiting, abdominal pain, jaundice, change in color of stools, change in bowel movements, chronic constipation or diarrhea, irritable bowel syndrome
8. ***Genitourinary Tract:*** Blood in urine, pain with urination, losing urine when couching or sneezing, frequent urge to urinate, do you have to get up and urine frequently at night? If so, how many times? _____times per night
9. ***Reproductive System:*** Any abnormal vaginal bleeding, vaginal dryness, pain or bleeding with intercourse, sexual dysfunction

   Are you sexually active? YES NO

10. ***Musculoskeletal System:*** Trauma, fractures, joint pain. swelling
11. ***Lymph Nodes:*** Enlargement or pain
12. ***Nervous System:*** Paralysis, numbness, new onset of headaches, migraine headaches
13. ***Emotional Health:*** Depression, anxiety, increased stress