

University of Rochester
UNIVERSITY HEALTH SERVICE
 Women's Health and GYN Exam

Name:		
MR#:		
Birthdate:	Age:	
Date:	Phone #: (H)	(W) (Cell)

Chief Complaint: _____

BP: _____ Temp: _____ Weight: _____ Pain: ____ / 10 N/A LMP _____

Drug Allergies: _____

Smoking Status: Current Former Never

MOA Signature _____

HEALTH HISTORY	No	Yes	Comments
Blood clots in your legs or lungs			
Stroke, heart attack, or angina (chest pain)			
Diabetes			
High blood pressure or high blood cholesterol			
Migraine headaches			
Kidney disease or frequent urinary tract infections			
Gallbladder disease or liver disease			
Significant feelings of depression or mood changes			
Surgical procedures or hospitalizations			
Other chronic medical conditions			

FAMILY HISTORY	No	Yes	Comments
Diabetes			
Heart attack or stroke before the age of 50			
Breast cancer or ovarian cancer			
Blood clots in legs or lungs			
Other significant family history			

MEDICATIONS						
Medication	Dosage	How often		Medication	Dosage	How often

HEALTH HABITS	No	Yes	Comments
Do you get 3 servings of dairy in your diet per day or take calcium supplements?			
Do you consume more than 2 cups of caffeinated beverages per day?			
Do you know your cholesterol level (lipid profile)?			
Get regular exercise at least 3 times per week			
On average, how many glasses of alcohol do you drink per week?			_____
Do you use recreational drugs?			
Do you perform routine self-breast examination?			
Have you ever had a mammogram?			If yes, when:

REPRODUCTIVE HEALTH HISTORY	No	Yes	Comments
Have you ever had an abnormal Pap smear?			
Do you have discomfort with periods?			
Do you experience bleeding between periods?			
Do you ever notice any discharge from your breasts?			
Do you experience symptoms of premenstrual syndrome severe enough to seek medical care? (e.g. mood or appetite changes)			
Have you ever had a vaginal or genital infection (e.g. yeast, herpes, chlamydia, gonorrhea, genital warts, syphilis, other)?			
Have you ever been exposed to Hepatitis B, HIV, or AIDS?			
Do you have any problems with leaking of urine?			

REPRODUCTIVE HEALTH HISTORY (cont'd)	No	Yes	Comments
Have you ever been in an intimate / sexual relationship? If yes: With a man? <input type="checkbox"/> No <input type="checkbox"/> Yes With a woman? <input type="checkbox"/> No <input type="checkbox"/> Yes			
Are you currently in an intimate / sexual relationship? If yes: With a man? <input type="checkbox"/> No <input type="checkbox"/> Yes With a woman? <input type="checkbox"/> No <input type="checkbox"/> Yes			
How old were you when you became sexually active?			Age: ____ <input type="checkbox"/> N/A
If you have had sexual intercourse/intimate relationships: Have you had intercourse/sexual activity in the last 2 months?			
Have you had intercourse/sexual activity with a new partner in the last 6 months?			
How many sexual partners have you had in your lifetime?			_____
Do you usually experience pain or bleeding with intercourse?			
Have you ever experienced unwanted sexual activity?			
Are you presently in a relationship where you feel threatened or unsafe?			
Do you have any sexual issues or questions you would like to discuss?			
Do you frequently experience sexual dissatisfaction?			

GYN / OB HISTORY	
Age of first period: _____ Average number of days between cycles: _____ Duration of your menstrual flow: _____ days Amount of your menstrual flow: <input type="checkbox"/> Light <input type="checkbox"/> Moderate <input type="checkbox"/> Heavy First day of last period: _____ Date of last Pap smear: _____	Number of pregnancies: _____ Number of deliveries: _____ Number of miscarriages: _____ Number of abortions: _____ Current method of contraception, if applicable: _____ Age at menopause, if applicable: _____ Are you taking estrogen replacement therapy? <input type="checkbox"/> No <input type="checkbox"/> Yes

SUBJECTIVE

Provider Comments: _____

OBJECTIVE

Thyroid: _____	Ext. Gen.: _____
Lymph: _____	Vagina: _____
Lungs: _____	Cervix: _____
Heart: _____	Uterus: _____
Breasts: _____	Adnexae: _____
Abdomen: _____	Rectum: _____
Other: _____	

Lab: Pap GC Chlamydia Lipid profile Mammogram Bone densitometry Vaginitis screen/Nugent score
 Other _____

NS: Trich____ Clue cells____ WBCs____ Other____ **KOH:** Whiff____ Yeast____ pH:____

ASSESSMENT

Healthy, normal exam Other (specify): _____

PLAN

Teaching: OC Rx Other contraception BSE 1st GYN Medication side effects Healthy Practices brochure
 STD Prevention/Safer Sex Osteoporosis prevention Emergency Contraception Folic Acid 400 mcg daily
 Mammogram ordered Smoking Cessation Other _____

Contraception: _____
Other: _____

Follow-up: _____

Provider Signature **Date**