## GREENVILLE MIDWIFERY CARE NEW GYN PATIENT HISTORY

Date: _____

**Name:** _____
**DOB:** _____ **AGE:** _____

**REASON FOR TODAY'S VISIT**: ☐ **ANNUAL EXAM** ☐ **OTHER:**
_____
_____

CURRENT MEDICATIONS / SUPPLEMENTS: _____
DRUG ALLERGIES AND REACTION(S): _____

**MEDICAL HISTORY:** Are you currently experiencing or have you in the past had any of the following (check all that apply and describe below):

☐ Anemia
☐ Asthma
☐ Autoimmune disorders
☐ Lung disease
☐ Shortness of breath
☐ Breast pain
☐ Breast surgery
☐ Breast lump
☐ Blurred vision
☐ Blood clots
☐ Cancer
☐ Diabetes
☐ Migraine headaches
☐ Stroke
☐ Heart disease /problem
☐ High blood pressure
☐ Heart murmur
☐ Liver disease/hepatitis
☐ Gallbladder problems
☐ Varicose veins
☐ Unexplained weight gain or loss
☐ Urinary infections
☐ Kidney disease
☐ Severe mood changes
☐ Psychiatric problems
☐ Depression/anxiety
☐ Eating disorder (anorexia/bulimia)
☐ Chicken pox /shingles or vaccine _____
☐ Hepatitis vaccine _____
☐ Tdap vaccine _____
☐ HPV vaccine _____

_____
_____

Do you smoke? ☐ No ☐ Yes ____# cigs/day Drink alcohol? ☐ No ☐ Yes _____ # drinks/day / wk Use recreational drugs? ☐ No ☐ Yes _____
Do you engage in regular intentional exercise? ☐ No ☐ Yes (Type/how often) _____

Have you ever been physically, sexually, or psychologically abused either as an adult or child? ☐ No ☐ Yes _____
Do you feel safe in your home /living environment / relationship with partner? ☐ Yes ☐ No _____

**FAMILY HISTORY:** Has anyone in your family had trouble with the following?
Include mother (**M**), Father (**F**), Brother (**B**), Sister (**S**), Aunt (**A**), Uncle (**U**), Grandmother (**GM**), Grandfather (**GF**):

☐ Anemia _____ ☐ Breast disease _____ ☐ Diabetes _____ ☐ Gyn cancer _____ ☐ Heart Attack before age 50 _____
☐ Bleeding problem _____ ☐ Cancer/type _____ ☐ High Blood Pressure _____ ☐ Stroke _____ ☐ Other hereditary disease _____

**GYN HISTORY:** Are you currently experiencing or have you ever had any of the following conditions:

☐ Abnormal pap ☐ Pelvic tumors / fibroids ☐ Vaginal infections ☐ Unusual vaginal discharge
☐ Pelvic infections (PID) ☐ Pelvic surgery ☐ Unusual vaginal bleeding ☐ Unusual "bumps", sores, or lesions
**PREGNANCY HISTORY:** # Pregnancies _____ # miscarriages / abortions _____ # tubal pregnancies _____
# full term deliveries _____ # preterm births (<37 wks) _____ # living children _____

**Menstrual history:** When was the first day of your last period? _____ ☐ Normal ☐ Abnormal _____
Age at first menses _____ _ How often do you have periods? _____ How long do your periods last? _____
Periods are _____ Regular _____ Irregular _____ Light ____ Moderate _____Heavy _____ Painful
Last Pap test _____ ☐Normal ☐Abnormal _____ Have you had a test for HPV? ☐ No ☐ Yes _____
Have you ever had sexual intercourse? ☐ Yes ☐ Vaginal ☐ Anal ☐ Oral Do you have sex with ☐Men ☐Women ☐Both
How often do you use condoms? ☐Always ☐Sometimes ☐Never Number of partners past 2 years _____ Length of time with current partner _____
Do you have any concerns related to sex that you would like to discuss today? ☐ No ☐ Yes _____

**Have you ever had any of the following**: ☐ Chlamydia ☐ Gonorrhea ☐ Genital Warts ☐ Genital Herpes (HSV) ☐ Trichomonas

Are you currently using any form of contraception (protection against pregnancy)? ☐ No ☐ Yes Method _____
What birth control methods have you used in the past? _____
Any other pertinent history or concerns: _____

**********PATIENTS STOP HERE**********

Provider notes: _____
_____
_____

**GREENVILLE MIDWIFERY CARE NEW GYN PHYSICAL EXAM**

NAME: _____ TODAY'S DATE: _____

MR#: _____ BP: _____ P: _____ R: _____ T: _____

DOB: _____ HT: _____ WT: _____ BMI: _____

AGE: _____ G ____ P _____ Urine dip: _____

Urine Hcg: ☐ Neg ☐ Pos Hgb: _____

**REVIEW OF SYMPTOMS:**

| | | | | | |
|---|---|---|---|---|---|
| Constitutional: | Negative | Weight loss | Weight gain | Fever | Fatigue |
| Eyes: | Negative | Vision changes | Other | | |
| ENT: | Negative | Ulcers | Sinusitis | Headache | Hearing loss |
| CV: | Negative | Orthopnea | Chest pain | Edema | Palpitations |
| RESP: | Negative | Wheezing | SOB | Cough | |
| GI: | Negative | Diarrhea | Bloody stool | Nausea/Vomiting | Indigestion |
| | | Constipation | Flatulence | Pain | |
| GU: | Negative | Hematuria | Dysuria | Urgency | Frequency |
| | | Dysparenuia | PMS | Abn vag bleeding | Abn vag discharge |
| Breast: | Negative | Pain | Discharge | Masses | |

| | | | | | |
|---|---|---|---|---|---|
| Skin: | Negative | Rash | Ulcers | Dry Skin | Pigmented lesions |
| Musculoskeletal: | Negative | Muscle weakness | Muscle or joint pain | | |
| Neurologic: | Negative | Syncope | Seizures | Numbness | |
| | | Trouble walking / balance | Memory problems | | |
| Psychiatric/Mood: | Negative | Depression | Crying | Severe anxiety | |
| Hem / Lymph: | Negative | Bruises | Bleeding | Adenopathy | |
| Endocrine: | Negative | Diabetes | Hypothyroid | Hyperthyroid | |
| | | Hot flashes | Hair loss | Heat/Cold intolerance | |

**GENERAL:** ☐ Well-developed ☐ Well-nourished ☐ Normal habitus ☐ Overweight ☐ Obese ☐ Underweight

| | NML | ABN |
|---|---|---|
| **NECK**: | | |
| NECK | ☐ | ☐ |
| THYROID | ☐ | ☐ |
| **CV:** | | |
| HEART SOUNDS | ☐ | ☐ |
| MURMERS | ☐ | ☐ |
| **GI**: | | |
| ABDOMEN | ☐ | ☐ |
| LIVER | ☐ | ☐ |
| SPLEEN | ☐ | ☐ |
| BREAST (R) | ☐ | ☐ ☐ Fibrocystic changes ☐ Hyphae |
| BREAST (L) | ☐ | ☐ ☐ Fibrocystic changes |

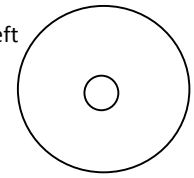
| | NML | ABN |
|---|---|---|
| **RESPIRATORY:** | | |
| RESP. EFFORT | ☐ | ☐ |
| LUNGS | ☐ | ☐ |
| **NEUROLOGIC:** | | |
| ORIENTATION | ☐ | ☐ |
| MOOD | ☐ | ☐ |
| **LYMPH**: | | |
| NECK | ☐ | ☐ |
| AXILLA | ☐ | ☐ |
| GROIN | ☐ | ☐ |

| | NML | ABN |
|---|---|---|
| **GYNECOLOGIC:** | | |
| EXT. GENITALIA | ☐ | ☐ _____ |
| BUS | ☐ | ☐ _____ |
| VAGINA/SUPPORT | ☐ | ☐ _____ |
| CERVIX | ☐ | ☐ _____ |
| UTERUS | ☐ | ☐ _____ |
| ADNEXA | ☐ | ☐ _____ |
| ANUS/PERINEUM | ☐ | ☐ _____ |

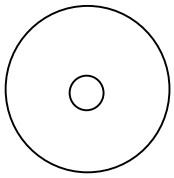
**Hemocult:** ☐ Neg ☐ Pos ☐ Not done

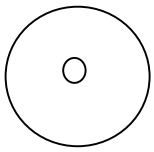
**Wet mount:** ☐ Saline ☐ KOH ☐ Clue Cells ☐ TRICH ☐ Whiff

Left



Right





Cervix

**ASSESSMENT:** ☐ Normal well-woman exam ☐ Other: _____

_____

_____

**PLAN:** ☐ Pap w/reflex HPV ☐ Pap w/HPV ☐ HPV only ☐ GC/CT Gonorrhea ☐ MAMMO ☐ TSH ☐ LIPIDS ☐ GLUCOSE ☐ HPV VACCINE

☐ RX: _____

☐ Other: _____

**EDUCATION/COUNSELING:**

☐ Birth control method: _____ ☐ Breastfeeding and LAM ☐ Plan B ☐ Nutrition / exercise

☐ HIV risk factors / safe sex ☐ STD information ☐ Vaginitis/yeast prevention ☐ UTI prevention ☐ Smoking cessation

☐ Domestic violence ☐ Pre-conception health / planning for pregnancy / birth ☐Peri-menopause / menopause

☐ Other: _____

**SIGNATURE: _____, CNM DATE: _____**