

**NAVAL HOSPITAL OAK HARBOR
GYN/PHC WOMEN'S HEALTH**

Date _____

Have you ever had any of the following? Please check and indicate when this happened.

	Yes	No	Date
Serious illness/hospitalization			
Severe headaches			
Thyroid disease			
Eye problems			
Epilepsy (seizures)			
Varicose veins			
Heart trouble (murmur)			
Stroke			
High blood pressure			
Lung disease (asthma, TB)			
Blood clots in leg or lung			
High cholesterol			
Uterine abnormalities			
Ovarian cysts			
Anemia			
Sickle cell anemia or trait			
Genetic condition			
Are you in menopause?			

	Yes	No	Date
Eating disorders			
Surgery of female organs			
Abdominal surgery			
Breast problems			
Stomach/intestinal problems			
Diabetes/diabetes in pregnancy			
Gallbladder disease			
Hepatitis (liver disease)			
Cancer			
Unusual or missed periods			
Bleeding between periods			
Vaginal Discharge			
Abnormal pap smears			
Colposcopy/cryotherapy			
Infection of female organs			
Sexually Transmitted Disease			
Depression			

Additional information (Explain "Yes")

FAMILY MEDICAL HISTORY

Have your parents, brothers, or sisters had any of the items listed below?

Yes	No	
		Cancer
		Heart Attack
		Diabetes
		Stroke
		High Cholesterol
		Osteoporosis
		Hypertension
		Blood Clots

Yes	No	
		Do you smoke? → Current Former Never If yes → How many cigarettes per day? _____ Number of years smoked? _____
		Since your last period, have you had unprotected sex (without using a birth control method)?
		Do you think you might be pregnant?
		Do you desire a method of birth control today?
		Do you fear for the safety of yourself or members of your family?
		Have you ever been forced to have sexual activity against your will?
		Breast Self Exam
		Exercise → Not at all – Occasionally – 3x / week or more
		Alcohol consumption /week →

CONTRACEPTIVE HISTORY

What is your present method of birth control?

	Abstinence		Foams/jelly
	Condoms		Diaphragm
	Depo Provera		Cervical Cap
	Norplant		Withdrawal
	IUD		Tubal Ligation
	Film/suppositories		Vasectomy (partner)
	Rhythm/NFP		Female condoms
	Birth Control Pill - type →		

How often is your period? → Every _____ Days

Addressograph

List Medication Allergies _____

Please list all medications and over-the-counter supplements that you are currently taking

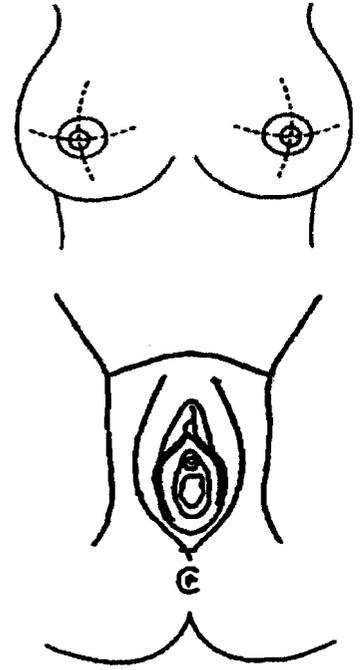
Date of your last PAP Smear → _____

Date of your last Mammogram → _____

Age: _____ Ht: _____ Wt: _____ Temp: _____ Pulse: _____ B/P: _____

Gravida: _____ Para: _____ SAB: _____ EAB: _____ LNMP: _____ Imm's Up-to-date? Yes No Unknown

	NL	NE	ABN
HEENT			
Thyroid			
Heart			
Lungs			
Breast/Axilla			
Back			
Abdomen/Trunk			
Extremities			
Perineum/Vulva			
Vagina			
Cervix			
Uterus			
Adnexa			
Anus/Rectum			
Skin			



Wet Prep Results = Yeast _____ WBC _____ Trich _____ Clue Cell _____ Amine _____

(As indicated)

Assessment:

Plan:

Laboratory Tests (As Indicated)

PAP Smear	<input type="checkbox"/>	VDRL	<input type="checkbox"/>	CBC	<input type="checkbox"/>	TSH	<input type="checkbox"/>
GC	<input type="checkbox"/>	HIV	<input type="checkbox"/>	FBS	<input type="checkbox"/>	LH/FSH	<input type="checkbox"/>
Chlamydia	<input type="checkbox"/>	HSV	<input type="checkbox"/>	Lipids	<input type="checkbox"/>	Mammo	<input type="checkbox"/>

Patient Education (As Indicated)

BSE	<input type="checkbox"/>	Family Planning	<input type="checkbox"/>	Nurse Educator	<input type="checkbox"/>
STD	<input type="checkbox"/>	Calcium	<input type="checkbox"/>	Diet	<input type="checkbox"/>
HRT	<input type="checkbox"/>	Exercise	<input type="checkbox"/>	Kegel	<input type="checkbox"/>

Immunizations Needed

dT	<input type="checkbox"/>	Pneumovax	<input type="checkbox"/>
MMR	<input type="checkbox"/>	Hepatitis B	<input type="checkbox"/>
Varicella	<input type="checkbox"/>		<input type="checkbox"/>

Examiner's Signature and Stamp _____