

COLUMBUS GYNECOLOGY RETURN EXAM

Appointment Date _____

Name _____ Preferred Name _____ Birth date _____

Family Physician _____ Preferred Pharmacy _____

What concerns do you have today?

New **medical problems** or **surgeries**: No Yes (describe)

MEDICATIONS—List all regularly used prescription, non-prescription drugs, vitamins, herbs, and pain relievers

I have a separate list of medications I will show you. I take no medications or supplements routinely.

I have been seen in the office in the past 4 months and there are no changes in my medications.

Drug / Dose / How often taken	Reason Taken	Need Refill	Drug / Dose / How often taken	Reason Taken	Need Refill

New **ALLERGIES** to medications: No Yes (what)

GYNECOLOGIC HISTORY

If still having menses:

1st day of last period _____

Periods occur every _____ days

Flow lasts _____ days

New sexual partner since last seen: Yes No

If yes, number of sex partners in lifetime:

0 / 1 / 2 – 5 / more than 5

Sex partners: Men Women Both

Marital status: Single Married

Divorced Separated

Currently sexually active: Yes No

Birth control method _____

None needed/reason:

Tubal Vasectomy

Hysterectomy Menopausal

Pregnancy since last visit: Yes No

CURRENT GYN SYMPTOMS (check all that apply)

Yes No

- Change in menstrual cycles
- Painful menstrual cramps
- Want to discuss birth control
- Bothersome menopausal symptoms
- Bleeding after menopause

Yes No

- Unusual vaginal discharge
- Problems with intercourse
- Want checked for sexually transmitted disease
- More than one sex partner in the last year

SOCIAL HISTORY/HABITS/SAFETY

Yes No

- Tobacco use? # packs/day _____
- Prior tobacco use? Year quit _____
- Drink alcohol regularly? # drinks/day _____
 Wine Beer Liquor
- Use street drugs? Type _____
- Exercise regularly
What? _____
- Eat a healthy, balanced diet
Particular type diet _____
- Caffeinated drinks? #drinks/day _____
 Coffee Soda Tea

Yes No

- _____ # Dairy products eaten/day
- Calcium supplement _____ mg
- Always wear your seatbelt
- Practice monthly self breast exam
- Use skin protection with sun exposure
- Regular dental exams
- Regular eye exams
- Worried about my personal safety

Occupation (if changed):

Please turn this page over for additional information.

New **family medical problems:** No Yes (describe)

REVIEW OF SYSTEMS

Please check any of the following problems that you may have. If no problems in a category, check "none". Indicate the name of any health care professional that is currently treating that problem.

GENERAL None
 Fever
 Weight loss 10+ pounds
 Weight gain 10+ pounds
 Tiredness Lack of energy
 Other _____
 Cared for by _____

HEAD/ENT None
 Vision problems
 Hearing problems
 Sinus problems
 Other _____
 Cared for by _____

NEUROLOGICAL None
 Severe headaches
 Dizziness Fainting
 Memory problems
 Other _____
 Cared for by _____

HEART None
 Chest pain Palpitations
 Fluid retention
 Swelling of legs
 Other _____
 Cared for by _____

LUNGS None
 Trouble breathing
 Excessive cough
 Other _____
 Cared for by _____

INTESTINAL None
 Abdominal pain
 Nausea Vomiting
 Diarrhea Constipation
 Indigestion Excess gas
 Bloating Bloody stools
 Other _____
 Cared for by _____

GENITOURINARY None
 Frequent urination
 Burning with urination
 Blood in urine
 Leak urine with urgency
 Leak urine with cough/sneeze
 Other _____
 Cared for by _____

MUSCOLOSKELETAL None
 Joint pain muscle pain
 Back pain
 Other _____
 Cared for by _____

SKIN None
 Skin problems
 History skin cancer
 Other _____
 Cared for by _____

BREAST None
 Breast problems
 Nipple discharge
 Other _____
 Cared for by _____

MOOD None
 Sad, down, depressed
 Lack of interest in activities
 Trouble concentrating
 Sleep too much or too little
 Irritable, moody, cry easily
 Anxious or nervous
 Suicidal thoughts
 Decrease in sexual desire
 Other _____
 Cared for by _____

ENDOCRINE None
 Hot flashes night sweats
 Heat or cold intolerance
 Excessive hair growth or loss
 Abnormal thirst
 Other _____
 Cared for by _____

BLOOD/LYMPH None
 Bruising or bleeding easily
 Enlarged lymph nodes
 Other _____
 Cared for by _____

ALLERGIES None
 Environmental allergies
 Cared for by _____

TESTS/IMMUNIZATIONS—*ONLY if performed elsewhere/ordered by another provider since your last visit with us*

Vaccination	Date last done	Blood work	Date last done	Test	Date last done
Hepatitis B		Blood sugar		Colonoscopy	
HPV/Gardasil		CBC blood count		Bone Density	
Influenza/Flu		Chemistry panel		Mammogram	
Pneumonia		Cholesterol/Lipids		Pap Smear	
Shingles/Zostavax		Thyroid		Pelvic Ultrasound	
Tetanus/dT/Tdap					

Thank you for taking the time to fill out the above information.

If you would like a nurse chaperone for your examination, please tell your physician prior to the exam.

If you would like to make a change in the persons to whom medical information may be released or how information is left for you, please tell your nurse so that you may complete a new form.

This paper will be shredded after the information is transferred to the computer unless you request that the paper itself be scanned into the record.