University of Rochester UNIVERSITY HEALTH SERVICE	Name:
	Birthdate: Age:
Date:	Phone #: (H) (W) (Cell)

Chief Complaint: ____

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

SOCIAL HISTORY	
Where are you from originally?	
Are you a student?	If so, what are you studying?
What is your occupation?	Employer:
Who lives at home with you?	

HEALTH HABITS	No	Yes	Comments
Do you get 3 servings of dairy in your diet per day or take calcium supplements?			
Have you had your cholesterol (lipid profile) checked in the past 5 yrs?			
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?			
Have you ever had a mammogram?			If yes, when:

REPRODUCTIVE HEALTH HISTORY	No	Yes	Comments
Have you ever had an abnormal Pap?			
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 received the HPV vaccine?			
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? ❑ No ❑ Yes With a woman? ❑ No ❑ Yes			
Are you currently in an intimate / sexual relationship? If yes: With a man? ❑ No ❑ Yes With a woman? ❑ No ❑ Yes			
How old were you when you became sexually active?			Age: ____ ❑ N/A
If you have had sexual intercourse/intimate relationships: 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:
❑ Light ❑ Moderate ❑ Heavy
First day of last period: __________
Date of last Pap: __________

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? ❑No ❑Yes

SUBJECTIVE

Provider Comments: ____

OBJECTIVE

Thyroid: ______________________
Lymph: ______________________
Lungs: ______________________
Heart: ______________________
Breasts: ______________________
Abdomen: ______________________
Other: ______________________

Ext. Gen.: ______________________
Vagina: ______________________
Cervix: ______________________
Uterus: ______________________
Adnexae: ______________________
Rectum: ______________________

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 ❑ 1st GYN ❑ Medication side effects ❑ Medications Reconciled
❑ Healthy Practices brochure ❑ STD Prevention/Safer Sex ❑ Osteoporosis prevention ❑ Emergency Contraception
❑ Folic Acid 400 mcg daily ❑ Mammogram ordered ❑ Smoking Cessation ❑ HPV Vaccine
❑ Other__________________________________
Contraception: ______________________________
Other: ______________________________

Follow-up: ______________________________

______________________________ ______________________________
Provider Signature **Date**