HCA Va
Virginia Gynecologic Oncology
An HCA affiliate

Today's Date: _____

INITIAL/ANNUAL VISIT or CONSULTATION

PATIENT INFORMATION

For your safety, this information will be updated yearly

Name: _____ DOB: _____ Age: _____
Phone: (home) _____ (work) _____ (cell) _____
How were you referred to our office? _____
PCP: _____

REASON FOR THIS VISIT: _____

Medical problems for which you see a medical provider (ex: asthma, depression, diabetes). Include name of provider.

_____ _____
_____ _____
_____ _____
_____ _____

Please list prior **hospitalizations**, **surgeries**, or **serious illnesses**. Include date.

_____
_____
_____
_____

Pregnancy History

Number of pregnancies: _____ Ectopic pregnancies: _____
Preterm births: _____ Number of vaginal births: _____
Miscarriages: _____ Number of C-Sections: _____
Abortions: _____ Number of living children: _____
Please list any prior pregnancy complications: _____
_____

GYN History

Age of first menstrual period: _____
Are you currently sexually active? Yes No
Do you use birth control? Yes No
If yes, what form? _____
Have you ever had an ABNORMAL pap smear? Yes No
Have you ever had a sexually transmitted infection? Yes No
Have you ever had an ABNORMAL mammogram? Yes No

Well Woman Care

Date of last pap smear _____
Date of last mammogram _____
Date of last bone density _____
Date of last colonoscopy _____

Social History

Are you: Married Living with Domestic Partner Divorced Single Widowed

Sexual Partner Preference (circle all that apply): Male Female

Highest Level of Education: _____

Are you employed outside the home? Yes No

If so, please list occupation: _____

Have you experienced physical, sexual, or emotional abuse? Yes No

Do you feel safe in your current living situation? Yes No

Do you use:

Cigarettes? Yes No If yes: Number per day _____ Years of use _____

Alcohol? Yes No If yes: Number per day _____ Years of use _____

Illegal drugs? Yes No If yes: Years of use _____

Family History

Breast cancer	Mother	Father	Other relative: _____
Uterine cancer	Mother	Father	Other relative: _____
Ovary cancer	Mother	Father	Other relative: _____
Bowel cancer	Mother	Father	Other relative: _____
Osteoporosis	Mother	Father	Other relative: _____
High blood pressure	Mother	Father	Other relative: _____
Diabetes	Mother	Father	Other relative: _____
Heart disease	Mother	Father	Other relative: _____
Stroke	Mother	Father	Other relative: _____
Other: _____	Mother	Father	Other relative: _____

Please list AGE and CAUSE of death, if applicable

Mother Living Deceased _____

Father Living Deceased _____

Brothers

Living _____ # Deceased _____ _____

Sisters

Living _____ # Deceased _____ _____

Patient: _____ DOB: _____ Today's Date: _____

ANNUAL/INITIAL VISIT or CONSULTATION

Chief Complaint: _____

HPI:

Age: _____

LMP: _____

Current birth control:

_____

Pain: _____

BP: _____

Pulse: _____

Resp: _____

Temp: _____

Ht: _____

Wt: _____

BMI: _____

Colonoscopy _____

Mammo _____

DEXA _____

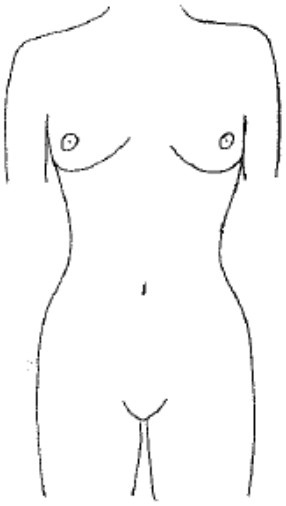
Review of Systems

(circle positive responses)

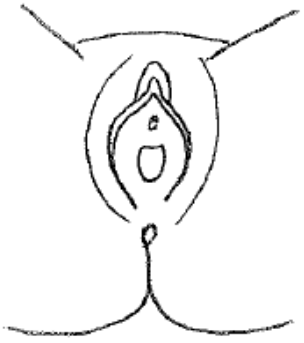
Constitutional	☐ Negative	Wt change	Fatigue	Sleep Disturbance	Other _____
Eyes	☐ Negative	Vision change	Other _____		
ENT/Mouth	☐ Negative	Ulcers	URI Sx	Other _____	
Cardio	☐ Negative	Chest Pain	Orthopnea	Dizziness	Other _____
Resp	☐ Negative	SOB/DOE	Wheezing	Other _____	
GI	☐ Negative	N/V	Diarrhea	Bloody Stool	Abd Pain
		Bloating	Other _____		
GU	☐ Negative	Hematuria	Dysuria	Incontinence	Other _____
Gyn	☐ Negative	Dyspareunia	Discharge	Bleeding	Other _____
Skin	☐ Negative	Rash	Blisters	Other _____	
Neuro	☐ Negative	Neuropathy	Other _____		
Psych	☐ Negative	Depression	Anxiety	Other _____	
Endocrine	☐ Negative	Diabetes	Hypothyroid	Hyperthyroid	Hot Flashes
Heme/Lymph	☐ Negative	Bruises	Bleeding	Adenopathy	
Musculoskeletal	☐ Negative	Weakness	Other _____		
Allergy	☐ Negative	Other _____			

Physical Exam

Habitus: Normal Overweight Underweight Well-groomed



		Normal	Abnormal (describe)
Neck	*neck	☐	
	*thyroid	☐	
Resp	*effort	☐	
	*auscultation	☐	
CV	*auscultation	☐	
	*periph vasc	☐	
GI	*abdomen	☐	
	*hernias	☐	
	*liver	☐	
	*spleen	☐	
Lymph	*neck	☐	
	*axilla	☐	
	*groin	☐	
Skin	*inspection	☐	
Neuro	*orientation	☐	
	*mood/affect	☐	



GYN	
Breasts	☐
External genitalia	☐
Urethra	☐
Urethral meatus	☐
Bladder	☐
Vagina/support	☐
Cervix	☐
Uterus	☐
Adnexa/parametria	☐
Anus/perineum	☐
Rectal	☐

Wet Prep: Hemoccult ☐ Negative ☐ Positive ☐QC

Assessment	**Plan**

Provider Signature: _____ Date: _____