Department of OB/GYN Gynecologic Follow Up Form

Name:_____ Date of Birth:_____ Pronouns: _____
Phone number for a detailed message with personal health information:_____

MHS Genesis patient portal is the standard method for results. □ I can use the Portal □ I CANNOT access the Portal
Where is your preferred pharmacy? □ Madigan Pharmacy □ Other (name & location) _____
Do you have paperwork that needs to be filled out today? □YES □NO

What are the two most important problems we can address for you today? _____
_____
What would make you completely satisfied with the healthcare you receive at this visit? _____
_____

Are you in pain today? □YES □NO If yes, where is your pain? _____Can you describe it? (ie sharp, dull, cramping) _____

What was the first day of your last menstrual period? _____ Sure / Unsure

What are you using for birth control right now (circle)?

Pills	Depo Provera Shot	Patches	Vaginal Ring	Vasectomy	Condoms
Tubes tied	Diaphragm/Cervical cap	Nexplanon	IUD	Same sex relationship	
Natural Family Planning/Lactation		No sex in last 3 months		Nothing	Attempting Pregnancy

Have you experienced any of the following in the last month? (check box for YES)

Constitutional:	□unexplained weight change □night sweats □fatigue □ appetite changes
Cardiovascular:	□chest pain □exercise intolerance □heart palpitations □fainting
Respiratory:	□cough □shortness of breath □wheezing
Gastrointestinal:	□abdominal pain □indigestion/acid reflux □bloating/fullness □cramping □nausea □vomiting □diarrhea □constipation □blood in stool
Genitourinary:	□ pain with urination □blood in urine □urinating frequently
Musculoskeletal:	□joint pain □stiffness □swelling □decreased range of motion
Skin/Breast:	□itching □rashes □breast pain □breast lumps □nipple discharge □breastfeeding
Neurological:	□tingling □numbness □limb weakness □poor balance □seizures □headaches
Psychiatric:	□depression □sleep problems □anxiety □difficulty concentrating □mood swings □relationship issues
Endocrine:	□Intolerance of hot or cold weather □dizziness □sweating
Hematologic:	□anemia □easy bleeding □ easy bruising □ nose bleeds

Preventative Health:
Would you like to be screened for sexually transmitted infections today? □YES □ NO
Do you want to become pregnant at some point in the future? □YES □ NO
Would you like to change your current form of birth control? □YES □ NO

What information can we provide you to help you improve your health today?

□Weight loss	□Heart health	□Healthy eating/nutrition	□Relationship help	□Exercise
□Sexual health	□Breast health	□Vaccines I should get	□Bone health	
□Quitting tobacco	□Safer sex practices	□Addiction (drugs, alcohol)	□ Advanced directives/Living will	
□Planning a healthy and/or future pregnancy		□Mental health/behavioral health		

Medications (please include all prescriptions, over the counter medications, prescription medications that weren't prescribed to you that you are taking, hormonal therapies, herbs, vitamins or alternative therapies):

To the best of my knowledge I have completed this form accurately. I understand that providing incomplete or inaccurate information can be dangerous to my health. Signature:
_____Date:_____

GYN Nursing Form

Vital Signs:
BP:_____ P:_____ RR:_____ T:_____ Ht:_____ Wt:_____

LMP:_____ Room:_____

Allergies:

1._____ **Smoke:** ☐ YES ☐ NO

2._____ **ETOH:** ☐ YES ☐ NO

3._____ **PAIN:** ☐ YES ☐ NO (__/10)

4._____ G___T___P___A___LC___

Gardasil: ☐ Received ☐ Not Received
☐ > 26 years old

REMEMBER TO PERFORM MEDICATION RECONCILIATION!