East Cooper OB/GYN

Women Devoted to Women

GYNECOLOGIC ASSESSMENT

Name: _____Today's Date: _____

Date of Birth: _____ Age: _____ Pharmacy Preference:_____

Please list the name of your primary care physician:_____

I am here today for a(n) ____ **annual exam** ____ **problem visit**

Date of last menstrual period: _____ Current form of birth control: _____

During the past year I have been (circle one)
Healthy Had minor illness Had major illness Had surgery Been hospitalized
Please specify: _____

Please list any medical problems for which you take medications or see a doctor regularly:
_____
_____

Please list any medications you are currently taking:

Name	**Dose**	**Refill needed? (please circle)**
_____		**Yes / No**
_____		**Yes / No**
_____		**Yes / No**
_____		**Yes / No**

Please list any Allergies:_____

Mood screening: During the past two weeks how often have you been bothered by the following:
Little interest or pleasure in doing things: N*ot at all / Several days / More than half the days / Nearly every day*
Feeling down, hopeless, or depressed: N*ot at all / Several days / More than half the days / Nearly every day*

Tobacco / Alcohol screening: Do you smoke cigarettes? *Yes / No* Do you vape? *Yes / No*
How many days in the past year have you had **heavy** alcohol consumption? _____

Please list the most recent date of the following tests:

Test	Location (hospital or doctor's name)
Pap smear _____	_____
Mammogram _____	_____
Bone density _____	_____
Colonoscopy _____	_____

Your Pap Will Be Sent To Gen Path

Would you like a chaperone present for a pelvic exam? (*please initial)* _____Yes _____No

*Please understand that we may need to schedule a return visit to address additional problems if noted above. While this may be inconvenient, it is necessary to comply with most insurance companies.