

Patient Name: _____ Acct.# _____

PATIENT SUMMARY SHEET

Family Physician: _____

Last Menstrual Period: _____ Any Problems? _____

Medications:

Name of medication & Date started:

Allergies:

Past Medical History:

Past Surgical History:

	YES	NO	
Hysterectomy	<input type="checkbox"/>	<input type="checkbox"/>	
Please Circle: Vaginal or Abdominal			Date: _____
Bladder Suspension	<input type="checkbox"/>	<input type="checkbox"/>	Date: _____
Dilation & Curretage (D/C)	<input type="checkbox"/>	<input type="checkbox"/>	Date: _____
Other: _____			Date: _____
Other: _____			Date: _____

OB/GYN History:

Age of First Menstrual Period: _____ Age of Menopause: _____

Number of Pregnancies: _____ Number of Births: _____ Number of Living Children: _____

History of STD's? _____ When? _____

Breast Problems? _____

Specific GYN Problems? _____

Family History:

	YES	NO	Family Member(s)
Breast Caner	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ovarian Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Colon Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Strokes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other: _____			_____

Completed by: _____ Physician Reviewer: _____