

Patients Please Complete the Following Section:

♥ PENINSULA WOMEN'S CARE, P.C. ♥

OPEL/NPEL

Name: _____ Birth date: _____ Age: _____ Appointment Date: _____
 Circle best phone# to reach you: Home / Work / Cell Phone # _____ OK to leave detailed test results? No / Yes
 1st Day of Last Period: _____ Was it normal? Yes / No: _____ Female Surgeries: _____
 # Pregnancies: _____ # Miscarriages: _____ # Abortions: _____ # Living: _____ Occupation: _____
 Current Method of Preventing Pregnancy: _____ Name of Pill or Hormones: _____
 Last Pap done: _____ Do you smoke? No / Yes #packs/day: _____ Drink Alcohol? No / Yes #drinks/week: _____
 Has anything changed in you or your family's medical history in the past year? _____
 What brings you to the office today? _____

B/P: _____ Wt: _____ Other: _____ Hgb: _____ Urine: Blood _____ Nitr _____ Glc _____ Pro _____ Leuk _____ / To be done by PCP
 Current Meds/Herbs: _____ Urine Pregnancy Test: Negative / Positive / Not indicated

PCP: _____

Allergies: None /

Detailed History

New Patient / Established Patient

Current and PFSH dated _____ were reviewed with patient and following changes noted: None / _____

Hx Present Illness(c/c+3) / ROS(v/s+1)

Detailed Exam (12)

General: Well groomed No acute distress Other:
Heart: Normal rate / rhythm Other:
Lungs: Bilat Clear Other:
Thyroid: WNL Enlarged Nodular
Breasts: Exam Deferred WNL Fibrocystic Masses Nipple discharge Other:
Abdomen: Benign Obese Other:
Bladder: WNL Fullness Tenderness
Urethra: WNL Masses Tenderness
Vulva: WNL Atrophic Inflamed Lesions Other:
Vagina: WNL Atrophic Inflamed Cystocele Rectocele Discharge:
 Wet Prep: Not indicated Hyphae: _____ Clue cells: _____ WBCs: _____ Trich: _____ Ph: _____
Cervix: Nullip Parous Absent Stenotic Friable + / - CMT Discharge:
Uterus: NSSC Absent Mobile AV MP RV Non / Tender Irregular Enlarged to:
Adnexa: Right = Non / Tender No Masses Absent Nonpalpable Other:
 Left = Non / Tender No Masses Absent Nonpalpable Other
Rectal: Confirms exam Deferred Hemorrhoids Fecal Occult Blood: - / + / Deferred / No Stool
Extremities: WNL /

A: 1. _____ 3. _____
 2. _____ 4. _____

P: GC/Chlamydiazyme done: Yes / Not Indicated Pelvic Ultrasound ordered: Yes / Not indicated
 Other Labs: None / _____ Done Today / Due: _____
 Rx samples given: None / _____
 Other Meds: None / _____
 Handouts given: None / _____
 RTC: As needed / _____
 Other Treatment / Instructions: _____