The College Of WILLIAM&MARY **Student Health Center**

GYN FORM

Please Use Black Ink

GYN Page _____

Date of Exam_____

Name_____ ID#_____ Birth date _____

Address_____Phone_____ Age_____

FAMILY HISTORY – Has anyone in your immediate family had trouble with the following? Include mother (M), father (F), brother (B), sister (S), aunt (A), grandmother (GM).

	No	Not Sure	Yes	Who
Clotting disorder	____	____	____	____
Breast disease	____	____	____	____
Breast cancer in female relative	____	____	____	____
GYN cancer	____	____	____	____
High blood pressure	____	____	____	____
Stroke	____	____	____	____
Blood clots	____	____	____	____
Heart attack before age 50 in immediate family	____	____	____	____
Osteoporosis	____	____	____	____

MEDICAL HISTORY – Information about you

	No	Yes	Now
Anemia	____	____	____
Headaches/frequent	____	____	____
Migraine headaches	____	____	____
Severe depression	____	____	____
Severe mood changes	____	____	____
Cancer _____	____	____	____
Eating disorder_____	____	____	____
Diabetes	____	____	____
Thyroid problem	____	____	____
Breast disease	____	____	____
High blood pressure	____	____	____
Shortness of breath	____	____	____
Heart disease/problem	____	____	____
Blood clots	____	____	____
Liver disease	____	____	____
Urinary tract infections in last year	____	____	____
Smoking			
# of cigarettes /wk _____			
how long? _____			
Alcohol use	____	____	____
# drinks/day_____			
# drinks/wk _____			
Recreational drug use	____	____	____
Regular exercise	____	____	____

GYN HISTORY

	No	Yes	Date
Pelvic disease	____	____	_____
Pelvic infections (PID)	____	____	_____
Pelvic surgery	____	____	_____
Abnormal pap report	____	____	_____ result _____
Positive HPV test	____	____	_____
Sexually transmitted infections (STIs)	____	____	_____
type _____	____	____	_____
Vaginal infections	____	____	_____
type_____			
# _____			
Pregnancy/abortion	____	____	_____
Gardasil vaccine	____	____	_____

Other_____

First day of last menstrual period_____ # periods/year_____

Any problems with your periods? _____

Last pap smear date _____ NA _____ result _____

SEXUAL HISTORY

Have you ever been sexually active? _____ No _____ Yes. If yes, _____ vaginal _____ anal _____ oral _____other
If yes, date of first intercourse or genital contact _____
Do you / have you had sex with _____ men _____ women
Have you ever been in a relationship where you have been threatened or harmed in any way? _____No _____ Yes
Condom/dental dam protection _____ Always _____ Sometimes _____ Never
Have you or any of your partners been at increased risk for HIV infection (multiple partners , bisexual experience, used IV drugs, multiple STIs)?
_____ No _____ Yes
Have you had unprotected sex (no condoms) since your last menstrual period? No / Yes Any missed birth control pills? ____ No ____ Yes.
Plan B taken in last year? _____ No _____ Yes. Are you currently using contraception? _____ No _____ Yes _____type
Any previously used contraceptive method?_____

Any other health care concerns you would like to discuss? _____ No _____ Yes (please list)_____

_____

Name_____ID#:_____

Allergies_____ Current meds._____

Ht. _____ Wt. _____ BP _____ Pulse _____

GENERAL PHYSICAL EXAM: _____ indicated _____ not indicated

Thyroid_____Lungs_____

Heart_____Abdomen_____

Extremities_____Other_____

BREAST EXAM: _____ indicated _____ not indicated

R: Nl Abnl Fibrous Cystic mass D/C Describe_____

L: Nl Abnl Fibrous Cystic mass D/C Describe_____

PELVIC EXAM; _____ indicated _____ not indicated

External genitalia:

Nl Abnl Vulvitis Folliculitis Condyloma Herpes

Bartholins cyst Lice/nits Other: Describe_____

BUS:

Nl Abnl Describe_____

Vagina:

Nl Abnl D/C Condyloma Other: Describe_____

Cervix:

Nl Abnl Cervicitis Erosion Eversion Cyst Polyp Herpes Condyloma

Mucopurulent D/C Cervical motion tenderness Other:_____

Uterus:

Nl Abnl Enlarged Smooth Nodular Mass

Ant/post ML R L Other:_____

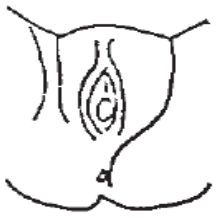
Adnexal:

R: Nl Abnl Tender mass Describe_____

L: Nl Abnl Tender mass Describe_____

Rectal:

Nl Abnl Blood Hemorrhoid Fissure Mass Other:_____



TESTS:

_____Pap (conventional/thin prep) _____Chlamydia _____Viral culture _____Saline/KOH _____Topical Acetic Acid (HPV)

_____ Gonorrhea _____HCG _____RPR _____ Serum HSV _____other

GYN lab notification by letter/ phone / consult _____ date _____ (initials)

ASSESSMENT:

_____

_____

_____

PLAN: Contraception Method: _____

_____ Gardasil vaccine recommended. Other treatment:_____

_____

_____

Follow-up:_____

HEALTH EDUCATION:

___ BSE instruction
___ ECP
___ BCP new start/renewal/consent
___ Nutrition/exercise
___ Depo Provera/new start/renewal/black box warning/consent
___ Patch/new start/renewal/consent
___ Ring/new start/renewal/consent
___ HIV risk factors
___ STI information
___ Diaphragm instruction
___ Info for condoms/spermicide
___Smoking cessation/alcohol
___Osteoporosis prevention
___Safe sex
___Domestic Violence
_____Other

Date:_____ Signature of Examiner_____NP/ PA/ MD