Centura Health Physician Group

Centura Health

OB/GYN Supplement
PG-2002 rev. 04/16

Name: _____ DOB: _____/_____/_____

Chief Complaint (reason for visit): _____

Method of Birth Control (if applicable): _____

Menstrual Periods First day of Last Menstrual Period: _____ ☐ N/A Reason: _____

Do you have regular periods? ☐ Yes ☐ No Cycle length (days between periods): _____ Length of bleed: _____ days

Bleeding is: ☐ Light ☐ Moderate ☐ Heavy Bleeding between periods? ☐ Yes ☐ No Pain with period is (0-10): _____

Pregnancy History:

___Total Pregnancies ___Term Birth ___Preterm Birth ___Miscarriages ___Multiples ___Ectopic ___Abortions ___Living Children

#	Month/Day/Year	Gender	Weight	Weeks Pregnant	Delivery Type	Anesthesia	Complications/Notes
1							
2							
3							
4							
5							
6							

Pap Smears Date of Last Pap: _____ Was it normal? ☐ Yes ☐ No

Have you ever had an abnormal Pap? ☐ Yes Date: _____ ☐ No

If yes, what was the treatment? ☐ Colposcopy ☐ Cone Biopsy ☐ Observation ☐ LEEP ☐ Cryosurgery

Menopause Symptoms ☐ Hot Flashes ☐ Irritability ☐ Vaginal Dryness ☐ Other: _____

Have you had any vaginal bleeding since menopause? ☐ Yes ☐ No

Are you currently taking hormone replacement therapy? ☐ Yes ☐ No

Previous hormone replacement therapy? ☐ Yes ☐ No

Breast Health Date of last mammogram: _____ ☐ Never ☐ Other Breast Imaging: _____

How often do you perform self-breast exams? ☐ Never ☐ Monthly ☐ Less than Monthly ☐ Other: _____

History of breast problems? ☐ Yes ☐ No Current: Masses/Lumps, Pain, Skin Changes/Redness? ☐ Yes ☐ No

Colon Health: Date of last colonoscopy: _____

History

Are you currently sexually active? ☐ Yes ☐ No Recurrent vaginal infections? ☐ Yes ☐ No

Have you ever had: ☐ Chlamydia ☐ Gonorrhea ☐ Hepatitis ☐ Herpes ☐ HIV ☐ Human Papilloma virus (HPV) ☐ Syphilis

Have you had the Human Papillomavirus (HPV) vaccine (i.e. Gardasil)? ☐ Yes ☐ No

Did you take the full course? ☐ Yes ☐ No ☐ Uncertain Have you ever used fertility medications? ☐ Yes ☐ No

Please list any medical, surgical, social or family history changes since your last visit: _____

_____

_____

Signature: _____ Date: _____

(Patient or Authorized Representative)

Centura Health Physician Group

Centura Health

Patient Label

Review of Systems
PG-2001 rev. 08/16

Please check any symptoms you've experienced over the **LAST ONE TO TWO WEEKS**:

General/ Constitution
- ☐ Activity Change
- ☐ Appetite Change
- ☐ Chills
- ☐ Diaphoresis (Sweating)
- ☐ Fatigue
- ☐ Fever
- ☐ Irritability
- ☐ Unexpected Weight Change

Ear, Nose & Throat
- ☐ Congestion
- ☐ Dental Problems
- ☐ Drooling
- ☐ Ear Discharge
- ☐ Ear Pain
- ☐ Facial Swelling
- ☐ Hearing Loss
- ☐ Mouth Sores
- ☐ Nosebleeds
- ☐ Postnasal Drip
- ☐ Rhinorrhea (Runny Nose)
- ☐ Sinus Pressure
- ☐ Sneezing
- ☐ Sore Throat
- ☐ Tinnitus (Ringing in the Ears)
- ☐ Trouble Swallowing
- ☐ Voice Change

Eyes
- ☐ Eye Discharge
- ☐ Eye Itching
- ☐ Eye Pain
- ☐ Eye Redness
- ☐ Photophobia (Sensitivity to Light)
- ☐ Visual Disturbance (Blurred Vision)

Respiratory
- ☐ Apnea
- ☐ Chest Tightness
- ☐ Choking
- ☐ Cough
- ☐ Shortness of Breath
- ☐ Stridor (Airway Obstruction)
- ☐ Wheezing

Cardiovascular
- ☐ Chest Pain
- ☐ Leg Swelling
- ☐ Palpitations (Irregular Heart Beat)

Gastrointestinal
- ☐ Abdominal Distention (Bloating)
- ☐ Abdominal Pain
- ☐ Anal Bleeding
- ☐ Blood in Stool
- ☐ Constipation
- ☐ Diarrhea
- ☐ Nausea
- ☐ Rectal Pain
- ☐ Vomiting

Endocrine
- ☐ Cold Intolerance
- ☐ Heat Intolerance
- ☐ Polydipsia (Abnormal Thirst)
- ☐ Polyphagia (Abnormal Hunger)
- ☐ Polyuria (Abnormal Urination)

Genitourinary
- ☐ Difficulty Urinating
- ☐ Dysuria (Painful Urination)
- ☐ Enuresis (Involuntary Urination)
- ☐ Flank Pain (Low Back Pain)
- ☐ Frequency Change (Urinary)
- ☐ Genital Sores
- ☐ Hematuria (Blood in Urine)
- ☐ Menstrual Problems
- ☐ Pelvic Pain
- ☐ Penile Discharge
- ☐ Penile Pain
- ☐ Penile Swelling
- ☐ Scrotal Swelling
- ☐ Testicular Pain
- ☐ Urinary Urgency
- ☐ Changes in Urine Stream
- ☐ Vaginal Bleeding
- ☐ Vaginal Discharge
- ☐ Vaginal Pain

Musculoskeletal
- ☐ Arthralgias (Joint Pain)
- ☐ Back Pain
- ☐ Gait Problems
- ☐ Joint Swelling
- ☐ Myalgias (Muscle Pain)
- ☐ Neck Pain
- ☐ Neck Stiffness

Skin
- ☐ Color Change
- ☐ Pallor (Paleness)
- ☐ Rash
- ☐ Wounds

Allergy/Immunologic
- ☐ Environmental Allergies
- ☐ Food Allergies
- ☐ Immunocompromised

Neurologic
- ☐ Dizziness
- ☐ Facial Asymmetry
- ☐ Headache(s)
- ☐ Light Headedness
- ☐ Numbness
- ☐ Seizures
- ☐ Speech Difficulty
- ☐ Syncope (Loss of Consciousness)
- ☐ Tremors
- ☐ Weakness

Hematologic
- ☐ Adenopathy (Swollen Glands)
- ☐ Bruising Tendency
- ☐ Bleeding Tendency

Behavioral
- ☐ Agitation
- ☐ Behavioral Problems
- ☐ Confusion
- ☐ Decreased Concentration
- ☐ Dysphoric Mood (Mood Changes)
- ☐ Hallucinations
- ☐ Hyperactive
- ☐ Nervousness
- ☐ Anxiety
- ☐ Self Injury
- ☐ Sleep Disturbance
- ☐ Suicidal Thoughts

Any other symptoms: _____

_____

_____ Patient or Guardian Name (please print)

_____ Patient or Guardian Signature

_____ Date