GREENVILLE HEALTH SYSTEM
Greenville Midwifery Care

NAME: ____
MR#: ____
Today's Date : ____________________________________

NEW GYN HISTORY AND PHYSICAL

CURRENT MEDICATIONS / SUPPLEMENTS: ______________________________ ______________________________ ______________________________	**CHIEF COMPLAINT / REASON FOR TODAY'S VISIT**: □ Annual exam □ Other: ______________________ ______________________________
NAME OF PRIMARY CARE PHYSICIAN / PHONE NUMBER: ______________________________	

MEDICAL HISTORY: Do you currently have or have you ever had any of the following?

	Anemia		Autoimmune disorders		Asthma / lung disease		Blood clots / clotting disorders
	Cardiac disease		High blood pressure		Irregular heartbeat		Stroke
	Diabetes		Thyroid disorder		Kidney disease		Frequent urinary tract infections
	Gall bladder problems		Bowel problems / IBS		Stomach problems / ulcers		Varicose veins
	Cancer		Liver disease/ hepatitis		Migraine headaches		Skin disorders / eczema
	Breast lumps		Eating disorder		Depression / Anxiety		Allergies to medications:
	Blood transfusion		Surgeries:				
	Other:						

PREGNANCY HISTORY:
Pregnancies ______ # full term deliveries ______ # preterm births (<37 wks) _____ # vaginal births _____ # Cesarean sections ______
miscarriages / abortions __________ # tubal pregnancies _______ # multiple births (twins, triplets) _______ # living children _________
Complications during pregnancy / birth: ____

FAMILY HISTORY: Please check all that apply:

	Mother	Father	Brother	Sister	G Mother	G Father	Aunt	Uncle
High blood pressure								
Diabetes								
Heart Disease / Heart attack before age 40								
Stroke								
Breast cancer								
Gynecological cancer								
Cancer (list type)								
Bleeding or clotting disorders								
Other inherited disorders								

Have you had the following vaccines? _____ Hepatitis vaccine _____ Tdap vaccine _____ Seasonal flu vaccine

Do you now or have you ever smoked cigarettes? □ Never smoked □ Quit / date _________________ □ Yes __________ # cigs/day
Do you drink alcohol? □ No □ Yes _______ # drinks / day / week Use illicit drugs? □ No □ Yes ____________________________

Have you ever been physically, sexually, psychologically / emotionally abused either as an adult or child? □ No □ Yes ______________________
____

Do you feel safe in your home / living environment / relationship with current partner? □ Yes □ No ____________________________
____

PROVIDER NOTES: ____
____
____

Have you experienced any of these symptoms frequently over the past 2-3 months? (Circle all that apply)

Constitutional:	Weight loss / gain	Fever	Fatigue		
Ear/Nose/Throat:	Hearing loss	Ulcers	Sinusitis Frequent headaches		
Eyes:	Discharge	Watery eyes	Visual changes		
Cardiovascular:	Chest pain	Heart racing			
Respiratory:	Wheezing	Cough	Shortness of breath		
Lymphatic:	Bruises	Bleeding	Swollen glands		
Endocrine:	Hot flashes	Hair loss	Heat / Cold intolerance		
Mood:	Depression	Crying	Anxiety		
Breast:	Pain	Lumps/Masses	Nipple discharge		
Skin:	Rash	Ulcers	Changes in skin lesions		
Musculoskeletal:	Muscle weakness	Muscle or joint pain			
Gastrointestinal:	Diarrhea / Constipation	Bloody stool	Nausea/Vomiting	Indigestion / Gas	Painful bowel movements
Neurologic:	Dizziness	Seizures	Numbness	Trouble walking / balance	Memory problems
Genitourinary:	Blood in urine	Difficult urination	Frequency	Incontinence	Urgency
	Abnormal vaginal discharge	Abnormal vaginal bleeding		Severe menstrual cramps / pelvic pain	

GYN HISTORY: Have you ever had any of the following:

☐ Abnormal pap ☐ Pelvic tumors / fibroids ☐ Frequent yeast infections ☐ Pelvic infections (PID) ☐ Chlamydia ☐ Gonorrhea

☐ Genital Warts ☐ Genital Herpes (HSV) ☐ Trichomonas ☐ Gynecologic surgery ________________________________

Date of last Pap smear ___________ ☐ Normal ☐ Abnormal / treatment____

Have you had the HPV vaccine? ☐ Yes ☐ No ☐Treated for infertility /type of treatment ____________________________________

☐ Other: ____

MENSTRUAL HISTORY:

When was the *first day* of your last period? ___________________ Was this period normal for you? ☐ Yes ☐ No ________________________

How often do you *usually* have periods? Every ______________________ ☐ Days ☐ Weeks ☐ Months

How many days do your periods *usually* last? ___________________ Periods are *usually* ☐ Light ☐ Moderate ☐ Heavy ☐ Painful ☐ Clots

For menopausal women: Have you ever or do you now take hormone replacement therapy? ☐ No ☐ Yes # years ________________________

SEXUAL HISTORY:

Have you ever had sex? ☐ No ☐ Yes Are you currently in a sexual relationship? ☐ No ☐ Yes Do you have sex with ☐ Men ☐ Women ☐ Both

# of partners past 2 years ________ Length of time with current partner ______________ Type: ☐ Vaginal ☐Anal ☐ Oral

How often do you use condoms? ☐ Always ☐ Sometimes ☐ Never Do you have pain with intercourse? ☐ No ☐ Yes

Do you have any sexual concerns that you would like to discuss today? ☐ No ☐ Yes ____

Are you currently using any method to prevent pregnancy? ☐ No ☐ Yes (type of method): ______________________________________
What birth control methods have you used in the past? ____
Do you have any concerns about birth control? ____

Any other concerns you would like to discuss today with the midwife? ____
____

PATIENTS STOP HERE*

PROVIDER NOTES: ____
____
____

GREENVILLE MIDWIFERY CARE NEW GYN PHYSICAL EXAM

BP: ___________ P: _______ R: _______ T: _________ NAME: ____

HT: __________ WT: _________ BMI: ___________ MR#: ____

Urine dip: ☐ Glucose ☐ WBC ☐ Protein ☐ Nitrites ☐ Spec. gravity _______ Hgb: __________ Urine Hcg: ☐ Neg ☐ Pos

GENERAL: Well-developed Well-nourished Normal habitus Overweight Obese Underweight

Orientation / Affect / Mood: ☐ Normal ☐ Other: ____

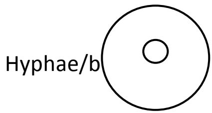
	NML	ABN		NML	ABN		NML	ABN
NECK			RESP. EFFORT			EXT. GENITALIA		
______________________________								
THYROID			LUNGS			BUS		________________________________
NECK			LYMPH (neck)			VAGINA/SUPPORT		________________________________
HEART SOUNDS			(axilla)			CERVIX		________________________________
MURMERS			(groin)			UTERUS		________________________________
ABDOMEN			LIVER			ADNEXA		________________________________
SPLEEN			CVAT			ANUS/PERINEUM		________________________________
BREAST (L):			BREAST (R):					

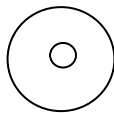
Hemocult: Neg Pos Not done

Wet mount: KOH Normal saline

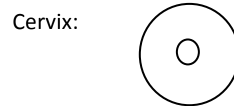
Clue cells Trich (+) Whiff WBC

Hyphae/b





Cervix:



ASSESSMENT: Normal Well-Woman Exam Other: ____

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____

PLAN: ☐ Pap w/reflex HPV ☐ Pap +HPV ☐ HPV only ☐ GC/CT Gonorrhea (Urine / DNA probe) ☐ TSH ☐ CBC ☐ CMP ☐ Lipid panel

☐ Mammogram ☐ Other: ____

Rx: ____

____

____

Refer to MD: ____

EDUCATION/COUNSELING:

Birth control method: _______________________________________ Pre-conception health / planning for pregnancy / birth

Safe sex practices / STD prevention	Vaginitis/yeast prevention	UTI prevention	Smoking cessation
Domestic violence	Peri-menopause / menopause	Nutrition / exercise	Plan B

☐ Other: ____

SIGNATURE: ____, **CNM** **DATE:** _______________________________

Follow-up note: ____

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Signature Date