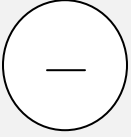
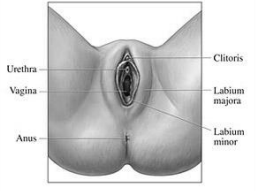
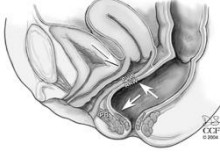
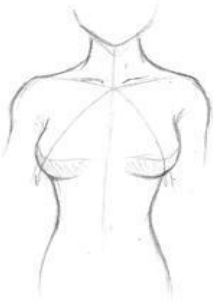
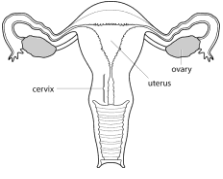


Initial Gynecology Profile

INITIAL PHYSICAL FORM				Check and Detail all Positive findings	    	LAB TESTS
Height						Hgb
Weight				Hct		
Blood Pressure				WBC		
Pelvic Exam	Normal	Abn	NE	Differential		
Ext. genitalia				Pregnancy		
Vagina				HIV		
Cervix				Gonorrhea		
Uterus				Chlamydia		
Ad nexus				HSV		
Rectum				VDRL Serology		
				Hepatitis		
General Physical	Normal	Abn	NE	PAP Smear		
Skin				Wet Mount		
HEENT				Culture		
Neck				Stool Occult Blood		
Chest				Blood Glucose		
Breasts				Cholesterol		
Heart				Thyroid Screen		
Lungs				Biopsy		
Abdomen				Mammogram		
Musculoskeletal						
Extremities						
Neurological						
Nutritional Assessment						
Not performed						
Apparently Adequate						
Apparently Inadequate						
Excessive caloric intake						
Diagnosis and Treatment Plans:				PAP GC Chlamydia Other Counseling/Education SBE STD Facts E.C.P.		
Signature: _____						



CHAPMAN UNIVERSITY

Examination Date: ___/___/___

Patient Identification (Please Print)					
Patient's Name:			Telephone:		
Address:			Daye of Birth:		
City:			Marital Status: S M D W		
Reason for Visit:			Medical Allergy / Sensitivity		
Pregnancy History (complete all information)					
# of pregnancies:		# of premature births:		# of miscarriages:	# of spontaneous abortions:
Medical History			Menstrual History		Lifestyle
Have you or any members of your family had:	You	Your family	First day of last menstrual period:	___/___/___	-Did your mother take DES or any other hormone when pregnant with you?
High cholesterol			Menarche (age of first period)	Interval (days between periods)	Length of period
Heart disease			Year:	Days:	Days:
Rheumatic Fever			Abnormalities		
High blood pressure			Discharge	Excessive bleeding	Pain
Asthma			Contraceptive History		
Tuberculosis			Types	Dates Used	
Thyroid problems Liver disease			Oral		
Stomach Bowels			IUD		
Gall bladder problems			Depo Provera		
Kidney problems			Diaphragm		
AIDS (HIV)			Spermicidal		
Hepatitis			Condoms		
Anemia blood disorder			Other		
Blood transfusion					
Allergies					
Cancer					
Infertility					
Gonorrhrea					
Herpes (HSV)					
Condyloma (HPV)					
Syphilis					
Birth defects/Inherited disease					
Sexual abuse/Domestic problems					
Breast Problems					
Female Sexual Problems					
Chlamydia					
No known medical problems					
Hospitalizations List operations/serious illnesses that required hospitalization:					- Have you ever had abnormal Pap test results?
					- Are you sexually active
					- Do you have more than one Partner
					- Is intercourse painful for you
					- Do you do monthly breast Exams
					- Have you had a mammogram
					If yes, date of your last mammogram ___/___/___
					- Do you exercise on a regular basis
					If yes, Type of exercise _____
					Hours per week _____
Month:	Year	Complications		Notes	
		Yes	No		
Do you use any of the following (enter Type):					
Alcohol					
Tobacco					
Caffeine					
Non Prescription drugs					
Street Drugs					