Patient Name:______________________________ DOB:____________________

Patient Summary Sheet

Family Physician:____________________________________

Last Menstrual Period:____________ Any Problems?________________________

Medications:

Name of medication & Date started:

____
____
____
____

Allergies:

____
____
____
____

Past Medical History:

____
____
____
____

Past Surgical History:

	YES	NO	
Hysterectomy	☐	☐	
Please Circle: Vaginal or Abdominal			Date:________________
Bladder Suspension	☐	☐	Date:________________
Dilation & Curretage (D/C)	☐	☐	Date:________________
Other:____________________________			Date:________________
Other:____________________________			Date:________________

OB/GYN History:

Age of First Menstrual Period:_____________ Age of Menopause:______________

Number of Pregnancies: ________ Number of Births:_______ Number of Living Children:_________

History of STD's?_____________ When?____

Breast Problems?____

Specific GYN Problems?____

Family History:

	YES	NO	Family Member(s)
Breast Caner	☐	☐	__________________________
Ovarian Cancer	☐	☐	__________________________
Colon Cancer	☐	☐	__________________________
Osteoporosis	☐	☐	__________________________
Heart Disease	☐	☐	__________________________
High Blood Pressure	☐	☐	__________________________
Strokes	☐	☐	__________________________
Diabetes	☐	☐	__________________________
Other: ___________________________			__________________________

Completed by:_________________________________ Physician Reviewer:____________________