COMMUNICATION DOCUMENT
FOR GYNECOLOGICAL SERVICES

FROM: OB/Gyn Physician: **Telephone #**

TO: Name of PCP

Patient Name: **ID Number:**

Date: **Age** **G** **P** **LMP** **Birth Control**

Allergies: **Medications:**

Chief Complaint:

Gyn History: Menarche: Frequency: Duration: Cramps

Discharge: Pelvic Pain: Urinary Sx's/Incontinence:

Abnormal Pap Smears: # Partners: STDs:

Breast Exam: Mammography:

Medical History:

Cholesterol:

Immunizations: Td Hep B HPV Varicella MMR Flu Pneumovax PPD

Surgical History:

Transfusions:

Family History:

Social History: Lives with: Occupation: Smoking: ppd

Alcohol: /wk Drugs: Victim of Abuse: Yes No

Review of Systems: Vision Hearing Skin Dental Neck Respiratory Cardiac GI Extremities Back

Examination: Weight: Height: BMI: B/P: Repeat: Pulse:

General Skin: Abdomen:

HEENT/Mouth: Pelvic External:

Thyroid: Vagina:

Breasts: Cervix:

Lungs/Heart: Uterus:

Back: Adnexa:

Neuro: Rectum:

Diagnostic Testing:

Results:

Patient Education

Breast Exam STDs Management of Menopause Aspirin Smoking Drugs/Alcohol Domestic Violence

Advanced Directives Exercise Nutrition/Calcium Seat Belts Guns Depression Stress

Assessment/Plan

Return:

Signature/Title