Gynecology Follow-Up Form

Name:	**Date:**
Primary Care Physician:	**Date of Birth:**
Reason for Visit:	
Comments:	

What is your current smoking status?

☐ Current every day smoker ☐ Current some day smoker ☐ Former smoker ☐ Never smoked

Since your last visit have you seen any other doctors/providers? (Circle) ☐ Yes ☐ No
If yes, please fill out the following information:

Doctor's Name:	Reason for Visit:

Please list any and all medication changes since your last visit:

Medication	Dose	Medication	Dose

Since your last visit have you had any major surgeries or illnesses? ☐ Yes ☐ No

If yes, describe:

Since your last visit have you had any blood work or radiology studies? ☐ Yes ☐ No

If yes, describe:

Reviewer's Name:	Reviewer's Signature:

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Matagorda Episcopal Health Outreach Program

REVIEW OF SYSTEMS							
Please answer yes if you have experienced any of the following symptoms since your last visit:							
		Yes	**No**			**Yes**	**No**
Constitutional	Fatigue			**Urinary**	Urgency		
	Fever				Frequency		
	Weight Loss/Gain				Dysuria (painful urination)		
	Night Sweats				Incontinence		
	Changes in Appetite			**Skin**	Changes in existing moles/lesions		
Gynecologic	Vaginal bleeding				Rash		
	Vaginal discharge				Itching		
	Pelvic Pain			**ENT**	Decreased Hearing		
	Vaginal Itching				Sore Throat		
Eyes	Wear glasses			**Musculoskeletal**	Muscle Aches		
	Wear contacts				Arthritis		
	Blurred vision				Chronic Back Pain		
Neurologic	Weakness			**Gastrointestinal**	Nausea		
	Dizziness				Vomiting		
	Vertigo				Diarrhea		
	Headaches				Constipation		
If yes, what type? □ sinus □ migraine □ tension				**Endocrine**	Hot flashes		
Breasts	Lumps				Hair Loss/Growth		
	Tenderness				Cold Intolerance		
	Nipple Discharge				Heat Intolerance		
Cardiovascular	Chest pain			**Psychiatric**	Anxiety		
	Irregular Heart Beat				Depression		
	Palpitations				Difficulty Sleeping		
	Leg swelling			**Hematologic/Lymphatic**	Easy Bruising		
Respiratory	Shortness of Breath				Excessive Bleeding		
	Wheezing			**Allergic/Immunologic**	Allergy Symptoms		
	Cough				HIV risk factors (IV drug use, high risk sexual behavior)		
Additional Concerns/Questions/Comments:							
Reviewer's Name:				**Reviewer's Signature:**			

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