Patient Care Notes

Please print:

Date:_____ Date of birth:_____ Age:_____

Patient name:_____

Medications (including OTC, birth control, and vitamins):_____

_____

Allergies:_____

First day of last menstrual cycle:_____

Problems with menstrual cycle:_____

Tobacco use: no_____ yes_____ — if yes, what type: _____ how much per day: _____

Alcohol: no_____ yes_____ — if yes, how much per: day_____ week_____ month_____

Weight concerns: _____

Family history of: ☐ Breast cancer ☐ Colon cancer ☐ Uterine cancer ☐ Ovarian cancer

_____

Personal history of: ☐ Heart disease ☐ Hypertension ☐ Respiratory disease (asthma, COPD, etc.)

☐ Diabetes Mellitus ☐ Anticoagulant use

Reason for visit/concerns: _____

_____

BP:_____ P:_____ Ht:_____ Wt:_____ BMI:_____

Annual 6 months 3 months

C/C HPI:_____

_____

_____

	WNL	AB	
HEENT	☐	☐	
Neck	☐	☐	
Adenopathy	☐	☐	
Heart	☐	☐	
Lungs	☐	☐	
Breast			
Skin	☐	☐	
Nipples	☐	☐	
Areolae	☐	☐	
Axilla	☐	☐	
Parenchyma	☐	☐	
Abdomen	☐	☐	Surgically absent
Vulva	☐	☐	
Vagina	☐	☐	
Cervix	☐	☐	☐
Uterus	☐	☐	☐
Adnexa	☐	☐	☐
Urethra	☐	☐	
Parametrium	☐	☐	
Rectum	☐	☐	
Anus	☐	☐	

Abnormal findings: _____

_____

_____

_____

_____

_____

Impression:_____

_____

_____

_____

_____

_____

Plan:_____

_____

_____

_____

_____

_____

_____

☐ Pap ☐ Chlamydia/GC

☐ Mammogram ☐ Colonoscopy ☐ Hemoccult

☐ Referral/ F/U: _____

___Week

___Month

___Year