JAMES J. STEIGERWALD, M.D.
DIANE LINK, RNC, NP

ASSOCIATES IN OBSTETRICS & GYNECOLOGY

JACK W. TUBBS, JR., M.D.
FAITH NICOLE BREWER, MSN, NP-C

ANNUAL EXAM

Date: _____/_____/____

Name:____

DOB ______/______/______ Age ______ GR _____ p _____ LMP _____/_____/_____ Last Pap _____/_____/_____

Temp ________ BP _________ Wt _______ Ht _________ BMI ______ Pap Result: _______________

Chief complaint: ____
____

Contraception: _____________________________

Screening History:

Last Mammogram: ______________________________

Last Colonoscopy: ______________________________

Last Bone Density: ______________________________

Last Blood Work: ______________________________

Immunization: Flu Pneumovax Gardasil Hepatitis

Gynecologic History:

Age at first menses: ______

Cycle: Regular? Y / N Painful? Y / N

How often? ______ # days it lasts _____

Flow? (circle one) light moderate heavy

Abnormal pap smears? Y / N Circle if appropriate:

Colposcopy Cryotherapy LEEP Cone

History of STD's? (circle) HPV Chlamydia Gonorrhea Herpes

Past Obstetric History:

Uncomplicated spontaneous vaginal deliveries? Y / N

Cesarean section? Y / N Any complications? Y / N

Weight of largest baby? ______________________

What significant medical conditions do you have?

____	Headaches	____	Cancer (any)
____	Seizure disorder	____	Kidney disease
____	Stroke	____	Osteoporosis
____	Eye problems	____	Bipolar disease
____	Thyroid problems	____	High blood pressure
____	Diverticulitis	____	Diabetes
____	Depression	____	Hypercholesterolemia
____	Heart attack	____	Arthritis
____	Heart disease	____	Endometriosis
____	Tuberculosis	____	Blood clot (DVT)
____	Asthma	____	Ulcer
____	Emphysema	____	Liver disease
____	Kidney stones	____	Breast cancer
____	Anxiety	Other:	__________________

Social History:

Smoking status: ____

Alcohol intake: ____

Recreational Drugs ____

Current Meds: ____

Allergies: ____
____

Supplements: ____
____

What surgeries have you had in the past?

______	Cesarean section	______	Joint replacement
______	Tubal Ligation	______	Plastic
______	Hysterectomy	______	Oral surgery
______	Laparoscopy	______	Breast biopsy
______	Abdominal surgery	______	Mastectomy
______	Heart Catherization	______	Hernia surgery
______	Gall bladder	______	Heart surgery
______	Back surgery	______	Tonsillectomy

Other surgeries__________________
____

Family Medical History:

Heart disease?	Y/N	relationship:	_________________
Diabetes?	Y/N	relationship:	_________________
Breast cancer?	Y/N	relationship:	_________________
Ovarian cancer?	Y/N	relationship:	_________________
Colon cancer?	Y/N	relationship:	_________________
Osteoporosis?	Y/N	relationship:	_________________
Other?	Y/N	relationship:	_________________

Comments:

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ANNUAL EXAM (page two)

Name:____ DOB:_____/_____/_____ Date:____/____/____
Reason for visit: ____

C ons ti t ut i ona l

[] Well developed [] Other ______________________
[] Well nourished [] Other ______________________
[] Habitus [] Obese [ ] Other ______________________
[] No deformities [] Other ______________________
[] Other ______________________

Respi ra t or y

R e s pira tor y E ffort [] Normal [] Abnormal ______________________
Lungs [] Normal [] Abnormal ______________________

Cardiovascular

Heart [] Normal [] Abnormal ______________________
Sounds [] Normal [] Abnormal ______________________
M ur murs [] Normal [] Abnormal ______________________
Perip hera l/Vas cular [] Normal [] Abnormal ______________________

Gas trointes tinal

Abdo me n [] Normal [] Abnormal ______________________
Her nia [] Normal [] Abnormal ______________________ Live r
[] Normal [] Abnormal ______________________ Splee
n [] Normal [] Abnormal ______________________
FOB [] Done [] Not Done ______________________

Lymphatic

Neck [] Normal [] Abnormal ______________________
Thyro id [] Normal [] Abnormal ______________________ Groin
[] Normal [] Abnormal ______________________
Other S ite [] Normal [] Abnormal ______________________

Skin

Inspect/Palpate [] Normal [] Abnormal ______________________

Ne ur ol ogic al /P s yc hol og ic a l

Orie ntat io n
[] Time [ ] Place [] Person [ ] Comments ______________________
M ood a nd A ffe c t
[] Normal [ ] Depressed [] Anxious [ ] Agitated [ ] Other ______________________

Gynecologic

Breasts [] Normal [] Abnormal ______________________
Rectal [] Normal [] Abnormal ______________________
Ext. Genita lia [] Normal [] Abnormal ______________________
Urethra [] Normal [] Abnormal ______________________
Bladder [] Normal [] Abnormal ______________________
Vagina l/Pe lvic Supp [] Normal [] Abnormal ______________________
Cervix [] Normal [] Abnormal ______________________ Uterus
[] Normal [] Abnormal ______________________
Ad ne xa [] Normal [] Abnormal ______________________
Anus/Rectum [] Normal [] Abnormal ______________________

Impression:	Plan:

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