REBECCA BREWER, M.D., LLC

Name _____ SSN_____ Date_____

DOB _____ Age _____ Phone #'s Home _____Work_____

Are you currently having problems with: (please circle any that apply)

fever	weight change	dizziness	headache	anxiety	depression	skin	bones - joints
muscles	nerves	eyes	ears	nose	sinus	throat	heart
blood pressure	breast lump	breast discharge	breathing	chronic cough	bloody sputum	swallowing	nausea
vomiting	bowel changes	rectal bleeding	pelvic pain	abdominal pain	kidneys	urinary leakage	bladder

Menstruation/periods _____ menopause problems/questions_____

Do you smoke? Y N _____ Drink alcohol? Y N _____ Other Drugs? Y N _____ Are you sexually involved? Y N

Do you need contraception? Y N Do you have any questions/problems re: sex? Y N _____

Are you safe at home? Y N _____

Current Medication: (by name and dosage): _____

_____

Drug allergies? _____ History of abnormal Pap test? Y N When?_____

Recent surgery or change in health? _____

If postmenopausal: date of last mammogram _____ bone density test _____

Update family history of major health problems _____

Name of primary care or referring provider _____

LMP _____ G ____ P ____ AB ____ Ht _____ Wt _____ B/P _____ Temp_____ UA _____

	Normal	Comment
	❒General Appearance	
	❒Neck	
	❒Thyroid	
Lungs	❒Resp. Effort	
	❒Auscultation	
Heart	❒Ausculation	
	❒Rate/Rhythm	
	❒Periph/vasc	
Ab	❒Masses	
	❒Tenderness	
	❒Liver	
	❒Spleen	
	❒Hernia	
	Scars: PF VML UMB Other	
Breast	❒ Scars:	
Pelvic	❒External	
	❒Meatus	
	❒Urethra	
	❒Bladder	

	Normal	Comment
	❒Vagina	
	Cystocele? Y N	Rectocele? Y N
	❒Cervix	
	❒Uterus	AV MID RV
	❒Adnexa	
	❒Anus/Perineum	Hemorrhoids? Y N
	❒Rectal	
	❒Hemoccult	
Lymph	❒Neck	❒Groin
	❒Axillary	❒ Supraclavicular
Skin	❒	
Neuro/Psych	❒	
	❒Mood Orientation: Person	Place Time

ASSESSMENT_____

_____

_____

PLAN_____

_____

_____

Counseling ❒Breast Self Exam ❒Folate ❒Exercise ❒Calcium ❒GI Screening

Tests Pap/Thin Prep Mammogram
GC/Chlamydia DXA
Hemoccult Lipids
Labs_____

_____
(Provider) (date)