

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 _____

Normal _____ Comment _____

General Appearance _____

Vagina _____

Neck _____

Cystocele? Y N _____ Rectocele? Y N _____

Thyroid _____

Cervix _____

Lungs Resp. Effort _____

Uterus _____ AV MID RV

Auscultation _____

Adnexa _____

Heart Auscultation _____

Anus/Perineum _____ Hemorrhoids? Y N _____

Rate/Rhythm _____

Rectal _____

Periph/vasc _____

Hemocult _____

Ab Masses _____

Lymph Neck _____ Groin _____

Tenderness _____

Axillary _____ Supraclavicular _____

Liver _____

Skin _____

Spleen _____

Neuro/Psych _____

Hernia _____

Mood Orientation: Person _____ Place _____ Time _____

Scars: PF VML UMB Other _____

ASSESSMENT _____

Breast _____ Scars: _____

PLAN _____

Pelvic External _____

Meatus _____

Urethra _____

Bladder _____

Tests Pap/Thin Prep _____ Mammogram _____

Counseling Breast Self Exam Folate Exercise

GC/Chlamydia _____ DXA _____

Calcium GI Screening

Hemocult _____ Lipids _____

Labs _____

 (Provider) (date)