LAURA R. STONE, M.D., P.C.

YEARLY UPDATE

PLEASE COMPLETE THIS INFORMATION TO HELP US PROVIDE THE BEST CARE FOR YOU

NAME: _____ AGE: _____ TODAY'S DATE: _____

Purpose of today's visit: _____ Routine yearly without problems.
_____ Routine yearly with problems / concerns / questions: _____

_____

GYNECOLOGY

Start date of last menstrual period (LMP): _____

Are you currently using birth control? ____N ____ Y, name_____

Are you currently on HRT? ____N ____ Y, name, dose _____

Any urinary or bladder complaints? ____N ____ Y, explain:_____

Number of sexual partners to date ____How long with current partner? _____ Any new partner(s) _____

Have you ever been or are you currently being physically, sexually, or emotionally abused?

____N _____Y ____ Maybe,_____

Any family history of gynecological cancer? ____ N ____ Y, who & type_____

BREAST

Date of most recent mammogram? ____ Where was it done? _____

Is there a family history of breast cancer? ____ Relationship & diagnosed at what age? _____

Do you perform self breast exams? ____ If Yes, how often _____

Have you noticed any breast masses? ____ If so, which breast _____

GENERAL

Please list any drug allergies _____

Please list **all** current medications, vitamins, herbal remedies, and dosages: _____

_____

Health care providers seen in the last 2 years, including naturalists, chiropractors, holistic healers:

Health Care Provider's Name	Specialty	Seen for

How often do you exercise? _____ Frequency &Type _____

Do you smoke? _____If Yes, how much _____ Numbers of years ____ Year stopped _____

Do you drink alcohol? _____If Yes, how much & how often _____

Do you use recreational drugs? _____ If Yes, which drug(s) & how often_____

SCREENING

Bone Density Scan: Have you had a bone density scan? _____ If Y, when & where? _____

Cholesterol: Year checked _____ Total cholesterol _____HDL _____ LDL _____

Colon/Bowel Cancer Screening: Stool checks for occult blood (cards) ____ N ____Y Year _____

If you are over 50, have you ever been screened for bowel cancer? ____ N ____Y, if Yes;

Method of screening: Colonoscopy ____N ____Y Year _____ by Dr. _____

Sigmoidoscopy ____N ____Y Year _____ by Dr. _____

WOULD YOU LIKE TO BE SCREENED FOR GONORRHEA AND CHLAMYDIA? _____ ***NO*** _____ ***YES***

PHYSICAL EXAMINATION
(TO BE COMPLETED BY DOCTOR)

NAME:_____ AGE:_____ DATE:_____

BP _____ P _____ HT _____ WT _____ UA _____ LMP _____

GEN: NL _____

THY: NL _____

BR: NL _____

NIPPLES NL _____

AXILLA NL _____

BSEXAM _____

PUL: NL _____

COR: NL _____

ABD: NL _____

URETHRAL MEATUS: NL _____

VULVA: NL _____ VSEXAM _____

VAG: NL _____

CX: NL _____

UTER: NSSC AV AF ML RV RF

_____

ADNEXA: LT: NL _____

RT: NL _____

RECT: NOT DONE NO MASS _____

HEME: NOT DONE NEG POS

ROS:

____No change patient

____No change family

WOULD YOU LIKE TO BE SCREENED FOR GONORRHEA AND CHLAMYDIA? ____ *NO* ____ *YES*