Concerns you would like addressed:

( ) Due for pap and breast exam

Medications? List ALL Medications/Supplements

Allergies?

I would like UHP to provide the following for me:

( ) Ob/Gyn services only
My family doctor is:_____

( ) Ob/Gyn and Primary Care Screenings and Immunizations

Date of your last period: / /

( )Hysterectomy ( )Ablation

Contraception: ( ) N/A ( )Tubal ( )Birth Control Pill

( )Other:_____ ( )Would like to discuss

Signature:

Patient:

DOB: Date:

Lab preference:
( ) St. Mary's Medical Center
( ) Bioreference Laboratory
( ) CHH*
( ) Other*_____

*I have been notified that I will need to take my labs with me today and deliver them to my lab for processing.

Pt Initials: _____

GYN

In Room #:

Age: **HT:** **WT:**

BP: **Temp:** **Pulse:**

G: **P:** **AB:** **LC:**

Nurse Initials:_____

Office Use. Details about responses/Provider notes:

Note to Scribe: ( ) All aspects of PE that are not noted above are to be considered negative. **Provider:** _____