LINDSTROM OBGYN

Name:_____ Phone#:(H)_____(W)_____

Date:_____ Referred by:_____

Age:_____G_____P_____ LMP_____Freq._____Duration_____

Date of Birth_____ Contraception:_____

CC:_____

HPI:_____

_____

_____

_____

_____

PM Hx Medical:_____

Surgical:_____

STD's:_____

Allergies:_____

Meds:_____

GYN Hx Menarche:_____OB Hx:_____

Last PAP:_____

Mammogram:_____

Soc. Hx Smoker: Y N _____ ETOH: Y N _____ Drugs: Y N_____

Marital Status:_____Occupation:_____

Fam. Hx Breast CA: Y N _____

PE BP T Wt. Ht.

HEENT Thyroid Abd

COR Lungs Breasts

Vulva Vagina

Cervix Uterus

Adenxa Rectal

A:_____

_____

P:_____

_____

_____

_____

_____

Labs/Studies Ordered