

Gyn Exam Form

Patient Name	:	Reshma Siya		Emirates ID	:	784-6478-3648736-8		
File No	:	4	DOB	:	1995-05-21	Nationality	:	Other
Gender	:	Female	Doctor's Name	:	Gyenec Test	Date	:	2024-02-17

FAMILY HISTORY:

Has anyone in your family had trouble with the following? Include mother (M), father (F), brother (B), sister (S), aunt (A), uncle (U), grandmother (GM), grandfather (GF).

	No	Yes	Not Sure	Who
Anemia	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Bleeding problem	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Breast disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
GYN cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Diabetes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
High Blood Pressure	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Stroke	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Heart attack before age 50	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Other Hereditary disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

MEDICAL HISTORY - Information about you

	No	Yes	Now		No	Yes	Now
Anemia	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Blurred vision	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Blurred vision	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Breast surgery	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Headaches/frequent	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Breast lump/discharge	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Migraine headaches	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	High blood pressure	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Stroke	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Chest pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Severe depression	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Shortness of breath	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Severe mood changes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Heart murmur	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Psychiatric problem	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Heart disease/problem	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Diabetes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Asthma	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Varicose veins	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Lung disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Blood clots	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Liver disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Redness and pain in leg	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Gallbladder problems Urinary tract	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	infections()	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Smoking	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Alcohol use	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
# of cigs day				# drinks/day			
how long?				# drinks/wk			
Recreational drug use()	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Eating disorder()	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Regular exercise ()	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>				

GYN HISTORY

	No	Yes	When (Date)
Pelvic tumors/fibroids	<input type="radio"/>	<input type="radio"/>	2/17/2024 12:00:00 AM
Pelvic infections (PID)	<input type="radio"/>	<input type="radio"/>	2/17/2024 12:00:00 AM
Pelvic surgery	<input type="radio"/>	<input type="radio"/>	2/17/2024 12:00:00 AM
Abnormal pap report	<input type="radio"/>	<input type="radio"/>	2/17/2024 12:00:00 AM
Result			
Vaginal infections	<input type="radio"/>	<input type="radio"/>	2/17/2024 12:00:00 AM
Unusual vaginal bleeding	<input type="radio"/>	<input type="radio"/>	2/17/2024 12:00:00 AM
Unusual vaginal discharge	<input type="radio"/>	<input type="radio"/>	2/17/2024 12:00:00 AM
Hepatitis B vaccine	<input type="radio"/>	<input type="radio"/>	
Pregnancy/abortion()	<input type="radio"/>	<input type="radio"/>	2/17/2024 12:00:00 AM
1.	2.	3.	

First day of last menstrual		Was last period normal	<input type="radio"/> Yes <input type="radio"/> No
Last pap date	2/17/2024 12:00:00 AM	result	

Periods started at age		Occur every		days Duration	days
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Periods are	<input type="radio"/> regular	<input type="radio"/> irregular	<input type="radio"/> light	<input type="radio"/> moderate	<input type="radio"/> heavy	<input type="radio"/> painful
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Do you do a breast self exam monthly?	<input type="radio"/> Yes	<input type="radio"/> No	
Have you ever had sexual intercourse	<input type="radio"/> Yes	<input type="radio"/> No	
If Yes,	<input type="radio"/> Men	<input type="radio"/> Women	

Number of sexual partners within past two years?		Length of time with current or most recent sexual partner?	
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Condom protection always	<input type="radio"/> Yes	<input type="radio"/> No
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Have any of your partners been in a high risk category for HIV infection (AIDS)?	<input type="radio"/> Yes	<input type="radio"/> No
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More than one partner(s)?		Bisexual?		Used drugs?		History of other STD's	
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Have you had unprotected sex (no condoms) since your last menstrual period?	<input type="radio"/> Yes	<input type="radio"/> No
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Any missed birth control pills?	<input type="radio"/> Yes	<input type="radio"/> No
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What are you doing now to protect yourself from HIV (AIDS)/STDs/Hepatitis B or C?	
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How many times have you used condoms in the last 10 acts of intercourse?	
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Have you ever had any of the following:



	Yes	No
Chlamydia	<input type="radio"/>	<input type="radio"/>
Gonorrhea	<input type="radio"/>	<input type="radio"/>
Genital Warts (HPV)	<input type="radio"/>	<input type="radio"/>
Herpes (HSV)	<input type="radio"/>	<input type="radio"/>
Hepatitis B	<input type="radio"/>	<input type="radio"/>

Any other pertinent history or concerns :

Pre-exam education :

☐ GYN exam film ☐ Contraception film ☐ STD film ☐ Breast Film

Current medications :

Sign here, only if all of your questions have been answered to your satisfaction	
Patient	Doctor
	
Patient Name Reshma Siya Date 2024-02-17	Doctor Name Gynec Test - Gynaecology (S6) Date 2024-02-17

