freMichael Frey, MD
OB/GYN

***NAME*______________________________ *age*_____ *Pain* _________ *Allergies* ______________

***Reason for visit*____*BP*__________*P*____________

LMP________________ Last PAP _______________________

Last Mammogram (over 40) ______________ Where did you do your last mammogram___________________

Last Colonoscopy (over 50) _______________ Last Dexa scan (over 65)__________________

Gardasil/ HPV vaccine (under 45): Yes No

PCP name/address____

CC:____

POB:____

PGYN: Menses: regular irregular Menarche: light moderate heavy Duration:

Fibroids/Ov cysts: Sexually active: yes no

BC: STDS: yes no

Breast issues: Depression/DV:

PMH____

PSH____

SOC______________________ Exercise _______ FH___________________________________

MEDICATIONS____