1555 Barrington Road, Suite 425
Hoffman Estates IL, 60169
Ph: (847)755-1111
Fax: (847)755-1166

880 W. Central Road, Suite 3300
Arlington Heights IL, 60005
Ph: (847)979-8363
Fax: (847)979-8670

GYNE CHECK LIST

ACCT# ________

NAME: ___________________________

DATE: ________________

DOB: ____________________________

GR__PARA__AB__ALIVE__

ALLERGIES: _______________________
____
____

NEED NURSE PRESENT DURING EXAMINATION: YES __ NO __

MEDICAL HISTORY: ____
____
____

OTHER PHYSICIAN TREATING PATIENT: ____

SURGICAL HISTORY: ____
____

FAMILY HISTORY: ____
(PERTINENT) ____

HISTORY OF ABNORMAL PAP: ____
____

IMMUNIZATIONS: ____

MEDICATIONS: ____
____

CONTRACEPTION: __________________________

DATE CHANGED: __________
DATE CHANGED: __________

MAMMOGRAM: DATE:____________
DATE:____________

CHOLESTEROL: _________________
18+ years _________________

HPV TYPING: DATE/RESULTS: ____________
DATE/RESULTS: ___________
DATE: ____________________
DATE: ____________________

SIGNATURE: __________________________________

DATE: ___________________