



SOUTH COAST
UROGYNECOLOGY

PROGRESS NOTE

DATE:		PT. NAME:		DOB:		ALLERGIES		
BP:	P:	R:	T:	WT:	HT:	LMP:	Reviewed - Unchanged <input type="checkbox"/>	
AGE	CIGARETTES:		CAFFEINE:		BLADDER SCAN			
G P	ETOH:		DRUGS:					
OUTCOME FROM LAST VISIT:						CURRENT MEDS		
CHIEF COMPLAINT(S):						Reviewed - See Med. List <input type="checkbox"/>		
PHYSICAL EXAMINATION			PAST MEDICAL HISTORY			EDUCATION		
	NORM	ABN	MEDICAL:			SMOKING CESSATION <input type="checkbox"/>		
H.E.E.N.T.						DIET INSTRUCTION <input type="checkbox"/>		
NECK						NUTRITIONIST CONSULT <input type="checkbox"/>		
CHEST						ACTIVITY/EXERCISE <input type="checkbox"/>		
BREASTS						SURGICAL:		
HEART						S.T.D. DISCUSSED <input type="checkbox"/>		
LUNGS						FAMILY PLANNING <input type="checkbox"/>		
ABDOMEN						ETOH DISCUSSED <input type="checkbox"/>		
EXTREM.						FAMILY/SOCIAL:		
VULVA						ED. MATERIAL GIVEN <input type="checkbox"/>		
VAULT						ADVANCED <input type="checkbox"/> YES		
CERVIX						DIRECTIVE <input type="checkbox"/> NO		
UTERUS						ROS:		
ADNEXA						SOFTENING EXERCISES <input type="checkbox"/>		
RECTAL						IC/OAB HANDOUTS <input type="checkbox"/>		
						SCREENING		ORDERED
						PAP TEST		
			MAMMOGRAM					
			LIPIDS					
			FBS					
			COLONOSCOPY					
			hsCRP					
			CBC		HORMONE			
			CHEM		THYROID			
			<input type="checkbox"/> CALL IF PROBLEM PERSISTS OR BECOMES WORSE					
			<input type="checkbox"/> DISCUSSED IMPORTANCE TO FOLLOW PLAN OF CARE					
IMPRESSION:						FOLLOW-UP VISIT		
PLAN:						OTHER		
SIGNATURE: _____ M.D.								
PHONE / OTHER COMMUNICATION:								