

**F.I.T. Health Services
Room A402, Phone (212) 217-4190**

**PLEASE ARRIVE ON TIME.
ALL PAPERS MUST BE COMPLETED BEFORE ARRIVAL.**

CANCELLATION OF WOMEN'S CLINIC APPOINTMENTS

PLEASE CALL AT LEAST 24 HOURS IN ADVANCE IN CASE OF CANCELLATION.
LATE ARRIVAL WILL BE RESCHEDULED ONLY ONE (1) TIME.

The Women's Clinic is a very popular clinic and appointments are at a premium; therefore, the Health Services has instituted the following policy:

A student who needs to cancel a Women's Clinic appointment must notify the Health Services at least 24 hours in advance. The only exception to this rule will be for an extreme emergency, which must be individually discussed with the appropriate Health Services provider. Failure to comply with these rules will result in losing your privilege to use the Women's Clinic.

PLEASE READ THIS BEFORE COMING TO YOUR WOMEN'S CLINIC APPOINTMENT

1. **BE ON TIME.** If you are late, you will have to reschedule your appointment and we will only do that once.
2. Know the date of your last menstrual period (LMP). The day it began is the first day of your last period – this is the beginning of your last cycle.
3. Come to the Health Services with your forms filled out.
4. If you have any questions, call the Health Services during regular hours at (212) 217-4190.

***** VERY IMPORTANT *****

For 24 hours prior to the test – DO NOT: 1) douche; 2) have sex; or 3) use vaginal medications.

Attention:

If you do not have the insurance provided by F.I.T.,
BRING YOUR INSURANCE CARD

Fashion Institute of Technology
HEALTH SERVICES

MEDICAL CONFIDENTIALITY PROTOCOL

Please Print

Date: _____

IN KEEPING WITH MEDICAL CONFIDENTIALITY PROTOCOL, WE WOULD LIKE YOU TO
FILL IN THE FOLLOWING SHOULD WE NEED TO CONTACT YOU REGARDING YOUR LAB
RESULTS.

1. STUDENT'S NAME: _____
SS# / STUDENT ID#: _____

2. DURING SCHOOL:
_____ MAIL: _____
Address

City, State, Zip
_____ PHONE: _____
_____ EMAIL: _____

3. DURING BREAKS:
_____ MAIL: _____
Address

City, State, Zip
_____ PHONE: _____
_____ EMAIL: _____

SIGNATURE: _____

F.I.T. Health Services Annual Gynecological Examination

Date: _____

Name: _____

SS#: _____

Age: _____

Medications: _____

Allergies: _____

Past Medical History: _____

Past Surgical History: _____

FAMILY HISTORY

(Please indicate who has the following: i.e. mother, father, and/or sibling)

Cancer: _____

Diabetes: _____

High Blood Pressure: _____

Heart Disease: _____

Other: _____

GYNECOLOGICAL HISTORY

First day of last menstrual period: ____/____/____

Last Pap Smear: ____/____/____

History of Abnormal Pap? Yes No If yes, when? ____/____/____ Treatment follow-up? Yes No

Are you sexually active? Yes No With (check one): Men Women Both

Pain during intercourse? Yes No

Anal intercourse? Yes No Current birth control method: _____

Have you ever been pregnant? Yes No # of pregnancies _____ # of miscarriages _____

of children _____ # of terminations _____

Do you douche? Yes No

What do you do to protect yourself from STD's and HIV? _____

Any current gynecological complaints (abnormal discharge, odor, pain, lesions, itching, painful/heavy bleeding, breast pain, breast discharges, or breast changes): _____

SOCIAL HISTORY

Tobacco use: No Yes _____ How much? _____ How many years? _____

Alcohol use: No Yes _____

Drug use: No Yes _____

Domestic Violence: No Yes _____

Rape: No Yes _____

Incest: No Yes _____

Regular exercise: No Yes _____

F.I.T. Health Services Annual Gynecological Examination

————— THE REMAINDER OF THIS FORM IS FOR THE USE OF THE HEALTH CARE PROVIDER —————

Name: _____

Date: _____

- Above history reviewed with patient
- Teaching provided regarding need for regular paps, STD prevention
- Teaching regarding BC method if newly starting
- No contraindications for oral contraceptives/patch, or ring
- ACHES discussed, warning signs given

BP: _____ **HR:** _____ **Ht:** _____ **Wt:** _____

REVIEW OF SYSTEMS: No changes since _____ / _____ / _____

- | | | | | | | |
|-------------------|--------------------------------------|--------------------------------------|---|--|---|--------------------------------------|
| 1. General | <input type="checkbox"/> Negative | <input type="checkbox"/> Wt. Loss | <input type="checkbox"/> Wt. Gain | <input type="checkbox"/> Fever | <input type="checkbox"/> Fatigue | |
| | <input type="checkbox"/> Other _____ | | | | | |
| 2. Eyes | <input type="checkbox"/> Negative | <input type="checkbox"/> Vision Chg | <input type="checkbox"/> Glasses/lenses | <input type="checkbox"/> Other _____ | | |
| 3. ENT | <input type="checkbox"/> Negative | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Sinusitis | <input type="checkbox"/> Tinnitus | <input type="checkbox"/> Headache | |
| 4. CV | <input type="checkbox"/> Negative | <input type="checkbox"/> Orthopnea | <input type="checkbox"/> Chest pain | <input type="checkbox"/> DOE | <input type="checkbox"/> Edema | <input type="checkbox"/> Palpitation |
| | <input type="checkbox"/> Other _____ | | | | | |
| 5. Resp | <input type="checkbox"/> Negative | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Hemoptysis | <input type="checkbox"/> SOB | <input type="checkbox"/> Cough | |
| | <input type="checkbox"/> Other _____ | | | | | |
| 6. GI | <input type="checkbox"/> Negative | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Bloody Stool | <input type="checkbox"/> N/V | <input type="checkbox"/> Constipation | <input type="checkbox"/> Pain |
| | <input type="checkbox"/> Other _____ | | | | | |
| 7. GU | <input type="checkbox"/> Negative | <input type="checkbox"/> Hematuria | <input type="checkbox"/> Dysuria | <input type="checkbox"/> Urgency | <input type="checkbox"/> Freq | |
| 8. Gyn | <input type="checkbox"/> Negative | <input type="checkbox"/> Abn. Bldng | <input type="checkbox"/> Dyspareunia | <input type="checkbox"/> Irregular Periods | <input type="checkbox"/> Menstrual problems | |
| | <input type="checkbox"/> Spotting | <input type="checkbox"/> Pelvic Pain | <input type="checkbox"/> Discharge | <input type="checkbox"/> Itching | <input type="checkbox"/> Other _____ | |
| 9. MS | <input type="checkbox"/> Negative | <input type="checkbox"/> Weakness | <input type="checkbox"/> Other _____ | | | |
| 10. Skin | <input type="checkbox"/> Negative | <input type="checkbox"/> Rash | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Other _____ | | |
| 11. Breast | <input type="checkbox"/> Negative | <input type="checkbox"/> Mastalgia | <input type="checkbox"/> Discharge | <input type="checkbox"/> Masses | <input type="checkbox"/> Other _____ | |
| 12. Neuro | <input type="checkbox"/> Negative | <input type="checkbox"/> Syncope | <input type="checkbox"/> Seizures | <input type="checkbox"/> Numbness | <input type="checkbox"/> Trouble walking | |
| | <input type="checkbox"/> Other _____ | | | | | |
| 13. Psych | <input type="checkbox"/> Negative | <input type="checkbox"/> Depression | <input type="checkbox"/> Crying | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Other _____ | |
| 14. Endo | <input type="checkbox"/> Negative | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hypothyroid | <input type="checkbox"/> Hyperthyroid | <input type="checkbox"/> Hot flashes | |
| | <input type="checkbox"/> Other _____ | | | | | |
| 15. H/L | <input type="checkbox"/> Negative | <input type="checkbox"/> Bruises | <input type="checkbox"/> Bleeding | <input type="checkbox"/> Adenopathy | <input type="checkbox"/> Other _____ | |

F.I.T. Health Service Annual Gynecological Examination

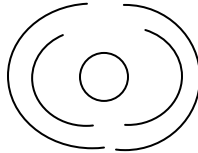
Name: _____

Date: _____

- LUNGS** Normal Breath Sound Abnormal _____
- HEART** Normal Rate/Rhythm Abnormal _____
- THYROID** Normal Abnormal _____
- BREAST** R - Normal L - Normal Abnormal Axillary Adenopathy Self-breast exam taught



- ABDOMEN** Normal Abnormal _____
- VULVA** Normal Abnormal _____
- VAGINA** Normal Abnormal _____ Abnormal Discharge _____
- Wetmount _____ Not indicated history
- CERVIX** Normal Abnormal Discharge _____ Lesions _____ CMT _____



- UTERUS** Normal Abnormal _____ Position _____
- RECTAL** Not done Normal External Condyloma Other _____
- ADNEXA** Normal Abnormal _____

Other physical findings based on history/ROS:

A: _____

P: _____

- Pap done GC/Chlamydia swab done

Provider Signature: _____ **MD NP**