

# GYN SURGERY REFERRAL FORM



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## PATIENT INFORMATION

NAME: \_\_\_\_\_ AGE: \_\_\_\_\_

PRIMARY CARE PHYSICIAN: \_\_\_\_\_

CURRENT OB/GYN: \_\_\_\_\_

## GYNECOLOGICAL INFORMATION

GYNECOLOGICAL PROBLEMS/ SYMPTOMS NECESSITATING GYN SURGERY CONSIDERATION: \_\_\_\_\_

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PRIOR TREATMENTS (MEDICAL OR SURGICAL FOR THE ABOVE): \_\_\_\_\_

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LIST ALL PRIOR SURGERIES: \_\_\_\_\_

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PRIOR LAB OR IMAGING RELATED TO GYN PROBLEMS: \_\_\_\_\_

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J. William Groves, Jr., MD

**PREGNANCY HISTORY**

NUMBER OF PREGNANCIES: \_\_\_\_\_ NUMBER OF DELIVERIES: \_\_\_\_\_

TYPE OF DELIVERY: VAGINAL \_\_\_\_\_ CESAREAN \_\_\_\_\_ LARGEST BIRTH WEIGHT: \_\_\_\_\_

NUMBER OF MISCARRIAGE OR OTHER PREGNANCY LOSSES: \_\_\_\_\_

DESIRE FOR FUTURE CHILDBEARING: YES NO

PREGNANCY COMPLICATIONS OR COMMENTS: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**MEDICAL INFORMATION**

CHRONIC MEDICAL PROBLEMS (such as heart disease, diabetes, high blood pressure, etc.): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

DAILY MEDICATIONS: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

BLOODWORK (ANEMIA, ETC.): \_\_\_\_\_

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\_\_\_\_\_

ULTRASOUND OR OTHER IMAGING RESULTS: \_\_\_\_\_

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MOST RECENT PAP TESTS & RESULTS: \_\_\_\_\_

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