Primary and Preventive Care
Program Plan and Evaluation for Implementation at
The University of North Carolina, Chapel Hill
Obstetrics and Gynecology Program

Jeannette Lager, MD
Wesley C. Fowler Jr., MD
Diane Calleson, PhD
UNC School of Public Health
UNC Department of Obstetrics and Gynecology
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Introduction

Obstetrics and gynecology is a unique field in that it provides several levels of care to female patients. Physicians who practice obstetrics provide preconceptual counseling, prenatal, intrapartum and postpartum care. Gynecologists provide medical and surgical care for gynecological disorders. At the same time, obstetricians and gynecologists are often seen as a patient’s primary care provider. Horton et al reported that 54% of women considered their obstetrician-gynecologist to be their primary care provider. On a national level, the American Board of Obstetrics and Gynecology and the Residency Review Committee have included primary care as module for training and specialty board exams. Additionally, Congress has recognized the importance of a “patient-centered medical home” where patients have a personal physician that provides comprehensive care and a team that takes collective responsibility for continuity of care. Since women will often see only one physician, their gynecologist, each year, it is imperative that obstetric and gynecology training programs have comprehensive training in primary care.

The Institute of Medicine Committee on the Future of Primary Care proposed the following definition for primary care:

“Primary care is the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community.”

As quoted by Hendrix et al, the executive board of the American College of Obstetricians
and Gynecologists further described a primary care physician as the following:

“[The primary care provider is] the physician who is directly accessible for their initial contact…This physician will see patients who have a specific or an undifferentiated complaint or patients who desire health maintenance through periodic health checkups. The primary care physician also provides continuity of care and is readily available to the patient when he or she has either a specific or nonspecific complaint. Such physicians perform initial evaluation and management within their expertise. The primary care physician advises when referral to another physician is indicated, coordinating subsequent and continuing care to assure the patient of appropriate comprehensive care.”

Given that patients consider their obstetrician-gynecologist to be their primary provider, it is important for residency training to reflect this. The Accreditation Council for Graduate Medical Education (ACGME) is responsible for accreditation of postgraduate medical training programs within the United States. The Residency Review Committee, a group within the ACGME, delineates the education components required in each specialty’s curriculum. Although, the committee provides guidelines and curriculum requirements (see Appendix A), it is up to the specific institution to develop a program that fulfils the requirements. To date, there has not been a published program designed to address the primary care component specifically.

After physicians complete their residency training, they are expected to prepare for board certification. In the field of obstetrics and gynecology, the American Board of
Obstetrics and Gynecology (ABOG) is an independent, non-profit organization that certifies obstetricians and gynecologists in the United States. ABOG provides a list of subjects that are included in the certification examinations. The topics include a section on “Office Practice Preventive/Primary care.” This section contains twenty-eight topics designated as areas that the obstetrician-gynecologist is responsible to cover (see Appendix B).

Therefore, we are proposing to focus on the educational objectives presented by the Residency Review Committee, which are included as topics for the American Board of Obstetrics and Gynecology for specialty board certification, in order to provide training in primary care to optimize patient care.

This paper will provide the background and context for the proposed program. The goals and objectives to approach primary care training and implementation will be delineated. The evaluation design and dissemination plan will also be included. The paper will conclude with a summary of the proposal and broader recommendations for the primary care plan in Obstetrics and Gynecology training.
Program Context

National Level

This program will be initiated at the University of North Carolina, Chapel Hill Obstetrics and Gynecology (OB/GYN) Residency Program. The OB/GYN program consists of several subdivisions: Gynecology-Oncology, Urogynecology and Pelvic Reconstructive Surgery, Advanced Gynecologic Laparoscopic Surgery, Maternal-Fetal Medicine, Reproductive Endocrinology and Infertility, and a Generalist division. The residents work in each of the divisions described above and have specific goals within each of the divisions. The residency component has admitted seven first-year residents annually since 2007 (six residents were admitted prior to 2007), for a total of 26 residents for the upcoming 2008-2009 year.

Primary care has not been formally taught in UNC’s residency program, although each resident has their own weekly continuity clinic where they see patients throughout their residency. These visits include general gynecology, obstetrics, and primary care. The Accreditation Committee of Graduate Medical Education (ACGME) oversees all of the residency programs nationwide to ensure that certain rules and regulations are followed. Within the ACGME, the Residency Review Committees (RRC) has been designated for each specialty. Their role is to provide program requirements for each specialty and ensure that residency programs are meeting those requirements.

At the completion of residency, the American Board of Obstetrics and Gynecology (ABOG) is the governing body that administers national board exams. They
describe the knowledge expectations for board-certified obstetricians and gynecologists. They also administer written and oral board exams.

The RRC and ABOG work in parallel to ensure that residency curriculum prepares physicians for board certification within the subspecialty. Approximately seven to eight years ago, the concept of an obstetrician gynecologist as a primary care physician was discussed. Studies found that the majority of women interact with the health care system only through their obstetrician gynecologist. Additionally women request direct access to their obstetrician and gynecologist without requiring a referral. As a result, in 1996, the RRC revised their program requirements to include primary care topics.

Based on these recommendations, the primary care component of education that is being implemented into UNC’s obstetrics and gynecology program is based on the RRC program requirements and in accordance with the ABOG examination guidelines.

Local Level

Given the requirements set out on a national level, the department of obstetrics and gynecology at UNC is supportive of a primary care program. Dr. Wesley C. Fowler, Jr., formerly Division Director of Gynecology Oncology, is now designated to implement any changes in the continuity clinic. Dr. AnnaMarie Connolly is the Resident Director and works directly with the residents to implement any changes in the residency program. Dr. Tom Ivester is involved in day-to-day improvements in quality of care. Dr. John Thorp is the of the Women’s Primary Care Division that most often staff the continuity clinic. Beth Harris RN is the clinic lead for the nursing staff. Dr. Daniel Clarke-Pearson is the OB/GYN Chair and oversees all aspects of the department. I am mainly working with Dr. Wesley Fowler to implement the primary care program. I am a former resident
of the UNC OB/GYN program, which provides insight on the structure of the clinics and residency program.

**Technical Feasibility**

Leadership support is vital to successfully implement the program. Dr. Clarke-Pearson fully supports the incorporation of primary care into the program. We also have the support of other key faculty to implement the program into the resident education and provide residents with clinical supervision that will also focus on management of primary care issues. At the same time we will work with the nurse manager, Beth Harris, to ensure that the support staff are performing the specific duties that the patients receive high quality primary care. The support staff’s participation is vital for the efficient flow of the clinic and accurate collection of patient information.

In addition to the faculty and support staff, patient questionnaires that are inclusive of primary care issues must be created as a written aid for patient care. We have worked with the Odum Institute, an organization that studies and creates questionnaires and survey materials, to review the questionnaires to create a patient friendly format. Given the large population of Spanish-speaking patients, we also needed the assistance of the Spanish translators to convert the questionnaire from English to Spanish. Since the questionnaire for the initial visit is extensive, the support staff is responsible for ensuring that the patient receives a questionnaire in the mail prior to the first visit to reduce the waiting time for the appointment while she is filling out the form. In the case that the form is not received or filled out, patients will be provided with the questionnaire at the time of the visit. For return visits, there will also be a short 1-page questionnaire verifying any changes in their medical history.
Potential Collaborators

As described previously, the Residency Review Committee and American Board of Obstetrics and Gynecology are actively involved in improving primary care training for residents. By working in collaboration with the two national organizations, we can ensure that the implementation of UNC’s primary care programming will be in accordance with the expectations defined by the RRC and ABOG. UNC’s Department of Obstetrics and Gynecology has been deeply involved in both organizations. If the program is successful at UNC, we hope that our program may be a model for other programs nationally.
Program Theory

The program theory fits best with the organizational change theory. Within the organizational change theory, the stages are the following:

1) Awareness of the problem
2) Initiation of action. This includes the adoption of change where policies are formulated and resources are allocated to support the program.
3) Implementation of the change
4) Institutionalization, where the program becomes entrenched into the organization. Once established within the organization, the faculty and staff internalize new goals and values.\textsuperscript{6}

When focusing specifically on our primary care program for the University of North Carolina Obstetric and Gynecology program, the topic of primary care for the obstetrician-gynecologist has been discussed in the literature since the 1975. Over time changes in the structure of hospital systems created the need to designate obstetrician-gynecologists as primary care physicians or specialists. Obstetrician-gynecologists have carved out a niche in both areas—specialized in the female reproductive system and primary care delivery for women. The Residency Review Committee recognized this dual role and revised the residency requirements for obstetric and gynecology departments nationally in 1996.

Policies that required residency programs to include a primary care experience have been reformulated over time. In the case of the UNC Obstetric and Gynecology Department, rotations in Family Medicine, Emergency Medicine and Internal Medicine have been utilized to meet the requirements. For various reasons, the faculty and
residents did not find them beneficial because they did not adequately address primary care. Since that time, primary care requirements have been met in the OB/GYN continuity clinic. There has been limited didactic teaching that has accompanied the primary care training.

The program that we are proposing would create a primary care component based on scholarly articles and evidence-based recommendations in primary care. It will include didactics on primary care by faculty and clinical tools focused on quality improvement.

The program will be implemented with the support of key faculty and staff, including the Department Chair of OB/GYN, Resident Director, and Continuity Clinic Director. Implementation will take place over 6 months to 1 year according to our short and long-term objectives. We hope that by ensuring a smooth integration of the program will allow for rapid institutionalization of the primary care component.
**Logic Model:**

<table>
<thead>
<tr>
<th>Resources/Inputs</th>
<th>Activities</th>
<th>Outputs</th>
<th>Short and Long Term Outcomes</th>
<th>Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>In order to accomplish our set of activities, we will need the following:</td>
<td>In order to address our problem or asset, we will conduct the following activities</td>
<td>We expect that once completed or underway, these activities will produce the following evidence of service delivery</td>
<td>We expect that if completed or outgoing these activities will lead to the following changes in 1-3 then 4-6 years:</td>
<td>We expect that if completed these activities will lead to the following changes in 7-10 years:</td>
</tr>
<tr>
<td>Identify the discrepancies and areas of improvement in:</td>
<td>Dr. Fowler</td>
<td>Revised patient form</td>
<td>1-3 years</td>
<td>7-10 years</td>
</tr>
<tr>
<td>- Resident education in primary care</td>
<td>- Discuss with clinic staff</td>
<td>- Mailed prior to appt</td>
<td>- 90% adherence to preventive care guidelines</td>
<td>- Implementation of similar programs nationally</td>
</tr>
<tr>
<td>- Continuity clinic flow</td>
<td>- Discuss with faculty</td>
<td>- Provided at time of apt if not completed</td>
<td>- Improve competence of residents in primary care</td>
<td></td>
</tr>
<tr>
<td>- Appropriate patients scheduled for continuity clinic</td>
<td>- Pilot patient forms</td>
<td>- Translated to Spanish</td>
<td>4-6 years</td>
<td></td>
</tr>
<tr>
<td>- Training in management of primary care issues</td>
<td>Dr. Lager</td>
<td>Work with chief resident</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Discuss w/ residents</td>
<td>Schedule educational sessions on primary care Training</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>- Develop patient forms</td>
<td>- Primary care lectures</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Based on RRC recommendations</td>
<td>Faculty support in continuity clinic</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Develop curriculum of primary care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Consult other PCPs</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>- Identify guideline articles</td>
<td></td>
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**Goals and Objectives:**

The goal of the program is to improve the education and training of primary care, ensuring better patient care and preparing residents for certification. To achieve this goal we have developed a set of short-term and long-term objectives. They serve to create a framework for the program implementation.

**Short-term Objectives**

<table>
<thead>
<tr>
<th>Objective 1</th>
<th>Strategies</th>
</tr>
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</table>
| By 12/07 Dr. Lager will identify areas for program planning in education and clinical care | ▪ Review RRC and ABOG requirements.  
▪ Identify primary care practices already in place |

<table>
<thead>
<tr>
<th>Objective 2</th>
<th>Strategies</th>
</tr>
</thead>
</table>
| By 12/07 Dr. Lager and Dr. Fowler will develop and pilot patient questionnaires | ▪ Dr. Lager will research patient questionnaires currently available  
▪ Dr. Lager will review current USPTF recommendations for preventive care  
▪ Dr. Lager will review current definitions of comprehensive visit for billing purposes  
▪ Dr. Lager will write patient questionnaire and review w/ Teresa Edwards from Odum Institute  
▪ Dr. Fowler will test in his clinic and in chief resident clinic  
▪ Any necessary changes will be made |

<table>
<thead>
<tr>
<th>Objective 3</th>
<th>Strategies</th>
</tr>
</thead>
</table>
| By 3/08 Patient questionnaires will be ready for clinic use (Appendix H & I)  | ▪ Linda McAlister, Dr. Fowler’s secretary, will send the form to Spanish translators  
▪ Dr. Fowler will meet with clinic leadership to integrate into clinic  
▪ Dr. Fowler will arrange plan to have patient questionnaire form mailed to new patients  
▪ Secretaries will be informed to administer questionnaire to patients that do not have form at time of visit  
▪ Secretaries will give return form to return patients  
▪ Nurse assistants will be instructed by |
<table>
<thead>
<tr>
<th>Objective 4</th>
<th>Strategies</th>
</tr>
</thead>
</table>
| By 3/08 Dr. Lager and Dr. Fowler will select topics for educational curriculum to improve knowledge, behavior and attitudes of residents in primary care | - Dr. Lager will review RRC recommended topics to compile list  
- Dr. Lager will discuss topics w/ Dr. Viera to find evidence based or expert committee guidelines  
- Dr. Lager will write final didactic topics and review with Dr. Fowler (See Appendix J) |

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<tr>
<th>Objective 5</th>
<th>Strategies</th>
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| By 4/08 Dr. Lager and Dr. Fowler will plan didactic sessions starting 6/08 | - Dr. Fowler will choose faculty to lead sessions  
- Dr. Fowler will discuss scheduling them w/ Dr. Connolly, Resident Director |

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<tr>
<th>Objective 6</th>
<th>Strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>By 6/08 Dr. Fowler will implement changes to make clinic more efficient</td>
<td>- Dr. Fowler will work with Drs. Connolly and Ivester and Beth Harris to implement ways to schedule primary care patients into appropriate resident clinic</td>
</tr>
</tbody>
</table>

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<thead>
<tr>
<th>Objective 7</th>
<th>Strategies</th>
</tr>
</thead>
</table>
| By 3/08 Dr. Lager and Dr. Fowler will develop WEBCIS preventive care module for OB/Gyn | - Dr. Lager will write up proposal (See Appendix K)  
- Dr. Fowler will review and modify as necessary  
- Dr. Lager and Dr. Fowler will meet with WEBCIS team to modify |

### Long-term Objectives

<table>
<thead>
<tr>
<th>Objective 1</th>
<th>Strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>By 6/09 Dr. Fowler will ensure that 100% of first year residents have participated in 75% of didactics over 1 year</td>
<td>- Dr. Fowler will discuss with Dr. Connolly best way to follow up, e.g. sign in sheets, email confirmation</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Objective 2</th>
<th>Strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>By 6/09 RRC evaluations will be performed and reviewed by Dr. Fowler</td>
<td>- Dr. Fowler will make necessary changes to primary care program based on RRC evaluation</td>
</tr>
<tr>
<td>Objective 3</td>
<td>Strategies</td>
</tr>
<tr>
<td>-------------</td>
<td>------------</td>
</tr>
<tr>
<td>By 9/09 Pre and post testing will be developed to evaluate knowledge behavior and attitudes of primary care practice</td>
<td>▪ Dr. Fowler will work with chief residents and session leaders to develop a pre-test and post-test</td>
</tr>
</tbody>
</table>
Literature Review of Selected Guidelines

Several organizations have released guidelines for preventive care, such as the American College of Obstetrics and Gynecology, United States Preventive Services Task Force, and the Association of Family Physicians. The guidelines are not consistent among the various organizations depending on the evidence and expert opinion of the task force assigned to the specific guideline. Given these differences, we reviewed the evidence available for colorectal cancer screening and osteoporosis screening. Colorectal cancer screening was chosen based on gender differences between diagnosis and anatomical location of colorectal neoplasia. Osteoporosis screening was considered to examine whether screening should be modified based on surgical menopause. Other areas that would be could be considered based on gender differences include cholesterol screening and aspirin dosages for myocardial infarction prevention.

Colorectal Cancer Screening

Colorectal cancer (CRC) is the third most common cancer and the second leading cause of death from cancer in men and women.\textsuperscript{7} It is estimated that 148,810 patients will be diagnosed with CRC and nearly 50,000 will die from the disease.\textsuperscript{7} The survival rate in early stage patients is 90% but can decrease to 10% if distant metastases are found. Despite this important epidemiological data, many patients do not have any form of CRC screening. Screening has been demonstrated to reduce the incidence of CRC, yet 46% of patients have had CRC screening.\textsuperscript{8} Thus, the first priority should be ensuring that patients are properly counseled to encourage screening, which has been discussed in several articles.\textsuperscript{8-10} The second issue is to consider whether the current guidelines should be modified based on gender. A Medline search was performed to review the evidence for
colorectal screening and included the following keywords: colorectal screening, colorectal guidelines, colorectal neoplasia diagnosis and gender differences.

One article that explored the issue of gender was published in the New England Journal of Medicine by Regula et al.\textsuperscript{11} This was a cross-sectional analysis of data from a large colonoscopy screening program in Poland. A total of 40 centers participated in the screening program nationwide and demographic data, colonoscopy and histopathological results were recorded in a central database. The program was financed solely by the Polish Ministry of Health. They included asymptomatic adults 50-66 years of age and excluded any patients that had symptoms that were suspicious for colorectal cancer, such as a recent change in bowel habits, unexplained weight loss and blood in stools that was not attributed to hemorrhoids. There were a total of 50,148 participants, of which 32,136 were women. They then used a multivariate logistic regression model to look at the relationship between clinical factors and the detection of advanced neoplasia. They used point estimates to determine the number needed to screen. The adjusted odds ratio was 2.08 (95% CI 1.89 to 2.28). The number needed to screen to detect advanced neoplasia was noted to be significantly lower in men in each age group compared to women. A summary of the number need to screen is listed below:

<table>
<thead>
<tr>
<th>Age group (years)</th>
<th># needed to screen in men (95% CI)</th>
<th># needed to screen (women) (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>40-49</td>
<td>23 (19-27)</td>
<td>36 (31-44)</td>
</tr>
<tr>
<td>50-54</td>
<td>17 (15-19)</td>
<td>28 (26-32)</td>
</tr>
<tr>
<td>55-59</td>
<td>12 (11-13)</td>
<td>22 (20-25)</td>
</tr>
<tr>
<td>60-66</td>
<td>10 (9-11)</td>
<td>18 (17-20)</td>
</tr>
</tbody>
</table>
This suggests that it would be worthwhile to consider the threshold at which we would want to begin screening tests. If men have a higher rate of detection in screening, one may consider changing the screening age of men to a lower age and start screening for women at a later age. For example, if the threshold was defined as a number needed to screen of 23, screening may begin at 40 years of age for men and 50 years of age for women. However, further studies would be necessary given the limited regional study and the type of study performed.

Another study that evaluated gender differences in colonoscopy screening was performed by the CONCeRN study investigators, Shoenfeld et al.\textsuperscript{12} This study enrolled asymptomatic, average risk women 50 to 79 years of age that were referred to one of four military medical centers. Women with any symptoms or signs concerning for colorectal cancer were excluded, e.g. positive fecal occult blood test within 6 months before referral, rectal bleeding, and unintentional weight loss. The primary objective of the study was to assess the predictive value of distal colon neoplasia (such as those found on sigmoidoscopy) with respect to advanced neoplasia in the proximal portion of the colon. The second objective was to quantify the prevalence and location of colonic neoplasias in women.

A total of 1464 women participated in the study. Of those women, 20.4\% were noted to have neoplastic lesions. This varied significantly with age where more lesions were found with increasing age. They then looked at the number of women who lesions were found in the distal colon; this simulated the area of the colon that would have been screened by sigmoidoscopy. They found the diagnostic yield of flexible sigmoidoscopy
was 34.7% --of the 72 cases detected by colonoscopy, 25 cases would have been detected by sigmoidoscopy alone. When this was compared a set of matched men who had participated in the VA Cooperative study 380, 66.3% of advanced neoplasia in men would have been detected if flexible sigmoidoscopy was performed—126 cases out of 190 cases of advanced neoplasia.

This finding suggests that while average risk women have a lower incidence of advanced neoplasia than men in the same age group, detection of neoplastic lesions using sigmoidoscopy is inferior in women. This suggests that colonoscopy should be the CRC screening method of choice for women.

This conclusion is reflected in the committee opinion released by the American College of Obstetrics and Gynecology in November 2007. The document reviews the risks and benefits of the various methods of CRC screening, but distinguishes colonoscopy every 10 years as the preferred method. Although this is different from the United States Preventive Task Force recommendations, which do not designate a preferred method, this is an important consideration for women’s health providers.

This year the American Cancer Society, the US Multi-Society Task Force, and the American College of Radiology jointly revisited their guideline for screening and surveillance for early detection of CRC and adenomatous polyps. They discussed that the goal of cancer screening is to reduce the incidence of advanced disease. The recognized the wide range of options for CRC screening and reviewed the pros and cons of each method. They concluded that colon cancer prevention should be the primary goal of CRC screening. Thus, tests that detect early cancer and may treat adenomatous polyps should be encouraged by clinicians who are willing to undergo an invasive test.
This would include flexible sigmoidoscopy, colonoscopy, air contrast barium enema and computed tomographic colonography. If there are any positive findings with flexible sigmoidoscopy, air contrast barium enema or computed tomographic colonography, referral for colonoscopy would be appropriate. The expert panel deferred to make any recommendations for demographic subgroups, such as gender. Their reasons included that “(1) there are no current data to indicate that CRC incidence and mortality in these groups would be positively affected by tailored screening recommendations; and (2) screening rates among all groups remain low under existing guidelines, and providing different (and, in some cases, more limited) screening options has the potential to increase confusion, complexity, and workload and thus might add additional barriers to screening that would affect all groups.”

In conclusion, it is most important to focus on providing patients with various alternatives of CRC screening with the goal to increase the number of patients who agree to participate in CRC screening. However, given the findings that show that women are at a significant risk of missing lesions that are precursors of colorectal cancer, I would encourage women to proceed with screening colonoscopy.

Osteoporosis Screening in Early Menopause

Osteoporosis is characterized by low bone mass and disruption of bone structure which can lead to fractures. Osteoporotic fractures occur in 50% of postmenopausal women at some point in their lives.\textsuperscript{15} This can be debilitating to patients, leading to 150,000 hospital admissions in patients over 65 years of age and more than 5 million days of restricted activity in patients over 45 years of age or older.\textsuperscript{15} The most concerning result of osteoporosis is hip fracture, which is fatal in 20% of patients and disables 50%.\textsuperscript{16}
The US Preventive Service Task Force has recommended osteoporosis screening for all women 65 years of age and older and high-risk women 60 to 64 years of age. However, the recommendations do not specify guidelines for women who have had early menopause due to premature ovarian failure or bilateral oophorectomy. Since these women may be diagnosed or treated at 30 to 39 years of age, they are at risk of estrogen deprivation decades before the USPSTF recommends screening. This is a subpopulation of patients that are diagnosed or receive treatment from a gynecologist; therefore, this is an important issue to address for the obstetrician-gynecologist who is providing primary care. This section will review the effect of early menopause on bone mineral density and fracture. Then we will review current guidelines and make recommendations for screening for osteoporosis in this subpopulation.

Several studies have looked at menopausal age and bone mineral density (BMD). One study performed by Hadjidakis et al investigated bone density patterns after normal and premature menopause. Their primary question was “is there a difference between bone mineral density and type or timing of menopause?”. The source population was the Outpatient Clinic for Metabolic Bone Disease in Athens, Greece. Five hundred and fourteen women were studied who had never received hormone replacement therapy. The women were divided into 3 groups: normal menopause (NMP), surgical menopause with bilateral oophorectomy before 45 years of age (SUMP) and premature/early natural menopause (EMP) which was defined as menopause earlier than 45 years of age. A questionnaire was given to the participants, height and weight were measured and bone mineral density measurements were obtained using Dual Energy X-ray Absorptiometry (DEXA). The women were divided into 5-year interval age
segments for analysis. The mean age at menopause was 49.1, 38.3 and 38.1 for the NMP, SUMP and EMP groups, respectively. They found that vertebral BMD values were significantly lower among the EMP women than the NMP women in the 45 to 50 and 50 to 55 year segments (P < 0.001). There was no significant difference between the vertebral BMD values in the EMP and SUMP women. SUMP women also had significantly lower vertebral values than the NMP women in the 45 to 50 year segment. This study suggests that women who experience early menopause may be at higher risk for fractures although they did not look at fracture rate as the endpoint.

Since early menopause decreases BMD, an important clinical endpoint is fracture rate. One study that examined the effects of early menopause on fracture risk was a cross-sectional study performed by van der Vort et al. This was a population-based study with 4203 participants recruited from a general practice setting. The menopausal women were divided into 2 groups: normal menopause and early menopause, which was defined as natural cessation of menstruation prior to 45 years of age. A questionnaire was given to the participants and BMD, height and weight measurements were obtained. Using multivariate logistic regression, they found that age over 70 years, BMD T-score less than 2.5 and early menopause were the only independent predictors of fracture. They also found that the fracture rate in the early menopause group was higher than the normal menopause group (OR=1.5, CI 1.2-1.8). This study concluded that early menopause is significantly associated with fractures after age 50 years and after menopause.

These studies show that early menopausal age is associated with a lower BMD values, osteoporosis and fractures. Since osteoporosis screening enables us to identify patients at an increased risk of fracture and patients that experience early menopause are
noted to have lower BMD scores and an increased fracture rate, it is worthwhile to consider early screening for this population. I will review the current screening recommendations by the US Preventive Service Task Force (USPSTF) and the World Health Organization (WHO) and then provide suggestions for the early menopausal population.

The USPSTF recommends osteoporosis screening for all women 65 years of age and older and high-risk women 60 to 64 years of age. The USPSTF lists the following risk factors but does not designate specific risk factors that would require early screening:

- Increasing age
- Diabetes mellitus
- Self-rated health (fair or poor)
- College education or greater
- Chronic conditions
- >100g of alcohol/week
- Unmarried
- Disability pension
- Smoking
- Maternal family member with history of fracture
- Long-term work disability
- Oophorectomy before age 45
- > 5 children
- >10 years since menopause

Although, the risk factors include oophorectomy and greater than 10 years since menopause, there are no clear recommendations for screening prior to 60 years of age.

The WHO released a technical report detailing recommendations for primary care. The WHO Scientific Group reviewed the morbidity of osteoporosis, acknowledged the difficulty of standard techniques to evaluate bone mineral density worldwide and considered methods to assess risk that do not require bone mineral density tests alone. The World Health Organization also introduced a tool to assess 10 year fracture risk called the FRAX model, which is available at the URL: http://www.shef.ac.uk/FRAX/index.htm. The FRAX model is a Poisson regression
model that was developed using risk factors based on international validity, available
evidence and those that could be modified by intervention. The model includes the
parameters listed in the following table:

Parameters used in the FRAX™ Fracture Risk Assessment Tool

<table>
<thead>
<tr>
<th>Parameters used in the FRAX™ Fracture Risk Assessment Tool</th>
<th>Smoking status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age/ Date of birth</td>
<td>Smoking status</td>
</tr>
<tr>
<td>Sex</td>
<td>Glucocorticoid use</td>
</tr>
<tr>
<td>Weight</td>
<td>Rheumatoid arthritis</td>
</tr>
<tr>
<td>Height</td>
<td>Secondary osteoporosis*</td>
</tr>
<tr>
<td>Previous fracture</td>
<td>Alcohol use &gt; 3 units/day</td>
</tr>
<tr>
<td>Parental fracture history</td>
<td>Femoral bone mineral density (as T-score or Z-score)</td>
</tr>
</tbody>
</table>

*Includes untreated hypogonadism in men and women (e.g. bilateral oophorectomy), inflammatory bowel
disease (e.g. Crohn’s disease and ulcerative colitis), prolonged immobility (e.g. spinal cord injury,
Parkinson’s disease), organ transplantation, Type I diabetes and thyroid disorders.

The incorporation of specific parameters in the regression model is useful for
subpopulations by incorporating additional risk factors to estimate the fracture risk. This
is particularly useful as it allows one to estimate risk prior to performing a bone mineral
density test. To quantify the appropriate risk threshold, the National Osteoporosis
Foundation estimated that osteoporosis treatment was cost-effective when the 10-year
probability of hip fracture reached 3%.24 Using the FRAX model, an average women in
the US who weighs 72 kilograms and whose height is 162 centimeters25 with secondary
osteoporosis (e.g. due to bilateral oophorectomy) would not reach the 3 percent threshold
until she reached 68 years of age. Based on the studies mentioned above, earlier
screening should be considered.

The USPSTF and WHO recommendations are useful for the general population for
osteoporosis screening. However, based on the study that demonstrates an increased
fracture risk in women who experience early menopause, osteoporosis screening should
be performed earlier than the standard recommendation. In cases where women
experience menopause or have a bilateral oophorectomy prior to age 45, osteoporosis screening should begin at age 50. This would enable physicians to appropriately treat and counsel patients who are at risk of osteoporosis and likely reduce the fracture rate in this high-risk population.
**Program Implementation:**

Several components are necessary for program implementation. These include activities, personnel and budget. A timeline of program implementation and personnel involved are listed in the following chart:

<table>
<thead>
<tr>
<th>Activity</th>
<th>Staff Involved</th>
<th>Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Program planning</td>
<td>Dr. Fowler &amp; Dr. Lager</td>
<td>10/07-12/07</td>
</tr>
<tr>
<td>Creation of Pt Form</td>
<td>Dr. Fowler, Dr. Lager, Reviewer from Odum Institute</td>
<td>11/07</td>
</tr>
<tr>
<td>Pilot Pt Form</td>
<td>Dr. Fowler</td>
<td>12/07-1/07</td>
</tr>
<tr>
<td>Establish curriculum</td>
<td>Dr. Fowler, RRC, ABOG</td>
<td>12/07-2/08</td>
</tr>
<tr>
<td>Identify preventive care guidelines</td>
<td>Dr. Lager</td>
<td>1/08-2/08</td>
</tr>
<tr>
<td>Find primary care articles</td>
<td>Dr. Lager, Dr. Viera</td>
<td>2/08-3/08</td>
</tr>
<tr>
<td>Create schedule of primary care educational sessions</td>
<td>Dr. Fowler, Dr. Kaminski</td>
<td>4/08-5/08</td>
</tr>
<tr>
<td>Meetings with clinic staff</td>
<td>Dr. Fowler</td>
<td>3/08-5/08</td>
</tr>
<tr>
<td>Implementation of patient form in clinic</td>
<td>Dr. Fowler, clinic staff</td>
<td>3/08-4/08</td>
</tr>
</tbody>
</table>

As shown above, the main activities are scheduling primary care lectures, reorganization of clinic structure, development and implementation of patient forms. There will be a total of 26 obstetric and gynecology residents participating in the primary care program. This includes 7 first year residents, 7 second year residents, 6 third year residents and 6 fourth year residents. The clinical program will be implemented within the UNC Obstetrics and Gynecology resident continuity clinic. The didactic component will be scheduled with the chief residents to ensure adequate lecture time.

There is currently no need for additional staff members. Faculty from generalist division will be most involved in the program as they commonly supervise clinic. Dr. Fowler is the Clinical Director and currently has time devoted to clinic improvement.
The equipment necessary for the program (copying machine, computer access) is already in place in the clinical setting.

**Challenges**

Although a program has the support of key players and the backing of the national organizations, there are still challenges with implementing a new program. These include staff buy-in, patient demographics, and resident schedules. I will discuss each of these in greater detail.

The implementation of this primary and preventive care program involves multiple levels of staffing. The patients must receive patient information forms prior to their visit, the secretaries are responsible for scheduling appropriate level patients for the appropriate level resident physician, the medical assistants are expected to assess the patient for vital statistics and ensure completion of the patient history. The resident physicians need to ensure that they receive all of the appropriate paperwork, ensure they have access to attending physicians for guidance in clinic, attend the didactic sessions, and apply the knowledge in their clinics. The didactic sessions are dependent on the participation of attending physicians to present the material. Evaluation methods, such as focus groups, will be critical to continually assess program implementation and identify areas of improvement.

UNC Hospitals cover a wide geographical area with a diverse patient population. Given this range of patients, it is sometimes difficult for patients to receive information by mail due to temporary housing situations, inaccurate information, and frequent moves. There is also a substantial portion of patients that are illiterate or have limited literacy and
would need assistance to fill out forms. The forms will be supplied upon arrival to the clinic and are available in English and Spanish, but would potentially delay their visit.

Lastly, the resident physicians have a busy rotating schedule. First year and second year residents spend four months at an outside facility and are unable to attend didactics during those months. Additionally, since OB/Gyn is a surgical specialty, there are sometimes unexpected patient care situations that would take precedence over the didactic session. In light of these challenges, we have planned for the didactic sessions to be repeated on a two-year cycle. This would enable the residents to ideally attend each lecture at least once.
**Introduction to Evaluation**

Once the primary care program is implemented into the Obstetric and Gynecology residency program, we will begin to administer evaluations for program assessment. The evaluation will allow us to monitor progress toward program goals and to determine if the program components are producing the desired outcomes—ensuring that patients receive up to date evidence-based primary care. Continual evaluation will also provide the opportunity for quality improvement and ensure that the program is meeting the objectives.

**Role of Evaluator**

The evaluation of the program will be performed using internal and external evaluators. The role of the internal evaluator is to ensure that the program is being implemented appropriately and that the program components are meeting the goals. Internal evaluation will monitor attendance of the didactic sessions, utilization of the primary care WEBCIS module and patient questionnaires. The internal evaluator will also provide feedback on the specific components of the program and recognize areas for program improvement.

The Residency Review Committee member selected to evaluate the University of North Carolina residency program will serve as an external evaluator. The RRC uses a standardized program to evaluate all programs nationally. The RRC will provide an outside perspective on the program’s strengths and weaknesses based on their evaluation. The details of their evaluation will be discussed in the evaluation design and methods.
Evaluation Design and Methods

The evaluation design will include descriptive and quasi-experimental methods, as described in detail below. The short-term objectives include assessments of the program plan, which can most easily be evaluated via interviews and focus groups. Once the clinic has fully integrated the patient history forms and the nursing assistants have had an in-service on their clinical duties in filling out the form, chart reviews will enable us to evaluate the utilization of the forms. Focus groups with various clinic levels will allow us to recognize the successful components and those that need improvement.

To address the long-term objectives, descriptive data will be obtained using focus groups and interviews. Quasi-experimental methods will be performed to evaluate pre and post testing after the didactic sessions and changes in the primary care component CREOG score. The specific evaluations are described below to address the objectives listed in the program planning section of this paper.

Short-term objectives

The first short term objectives (Objectives 1-4) are described in detail in the program design and appendix.

Objective 5: By 4/08 Dr. Lager and Dr. Fowler will plan didactic sessions starting 6/08

<table>
<thead>
<tr>
<th>Evaluation Questions</th>
<th>Participant</th>
<th>Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Were the didactic sessions scheduled?</td>
<td>Chief resident</td>
<td>Interview</td>
</tr>
<tr>
<td>2. When were they scheduled?</td>
<td>Chief resident</td>
<td>Interview</td>
</tr>
<tr>
<td>3. Who attended?</td>
<td>Chief residents</td>
<td>Interview</td>
</tr>
<tr>
<td>4. Was a sign-in sheet available for each session to assess attendance?</td>
<td>Residents</td>
<td>Sign-in sheet</td>
</tr>
<tr>
<td>5. How were the instructors chosen?</td>
<td>Dr. Fowler</td>
<td>Interview</td>
</tr>
</tbody>
</table>
6. Were there any problems with the sessions?
7. Are there areas for improvement?

<table>
<thead>
<tr>
<th>Evaluation Questions</th>
<th>Participant</th>
<th>Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>Were patient waiting times improved?</td>
<td>Front desk employees</td>
<td>Interview</td>
</tr>
<tr>
<td>Were patients assigned to the appropriate level of resident?</td>
<td>Residents</td>
<td>Interview</td>
</tr>
<tr>
<td>Of total number of patients seen, how many filled out the patient history form?</td>
<td>Chart review</td>
<td></td>
</tr>
<tr>
<td>Did the nurses fill out the appropriate boxes in the form?</td>
<td>Nurses Residents</td>
<td>Focus groups</td>
</tr>
<tr>
<td>What were the challenges to implementing changes?</td>
<td>Chief residents and residents</td>
<td>Focus groups</td>
</tr>
<tr>
<td>What is working well?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Objective 6: By 6/08 Dr. Fowler will implement changes to make clinic more efficient

<table>
<thead>
<tr>
<th>Evaluation Questions</th>
<th>Participant</th>
<th>Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Has the WEBCIS preventive care module been completed?</td>
<td>Chief residents &amp; Residents</td>
<td>Focus groups</td>
</tr>
<tr>
<td>2. Is it being used?</td>
<td>Attending physicians</td>
<td>Interviews</td>
</tr>
<tr>
<td>3. What percentage of patients has active preventive care information?</td>
<td></td>
<td>Chart review of WEBCIS</td>
</tr>
<tr>
<td>4. Is health care maintenance being performed on time?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Is it easy to use?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. What can be improved?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Long-term Outcomes

**Objective 1:** By 6/09 Dr. Fowler will ensure that 100% of first year residents have participated in 75% of didactics over 1 year

<table>
<thead>
<tr>
<th>Evaluation Questions</th>
<th>Participant</th>
<th>Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Did 100% of first year residents participate in didactics?</td>
<td>Chief resident</td>
<td>Sign-in sheet review</td>
</tr>
<tr>
<td>2. What percentage of all the residents participated in didactics?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. At the time of graduation, did every resident have each didactic topic at least once?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Are the didactics scheduled at a time that the residents are available?</td>
<td>Residents</td>
<td>Interviews</td>
</tr>
<tr>
<td>5. Is there a better method to schedule the didactics?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. How effective are the didactics?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Are the didactics meeting their objectives?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Could other methods be used?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Objective 2:** By 6/09 RRC evaluations will be performed and reviewed by Dr. Fowler

<table>
<thead>
<tr>
<th>Evaluation Questions</th>
<th>Participant</th>
<th>Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Were RRC evaluations performed and summarized?</td>
<td>Dr. Fowler</td>
<td>RRC evaluation summaries</td>
</tr>
<tr>
<td>2. Have they been reviewed?</td>
<td>Dr. Fowler</td>
<td></td>
</tr>
<tr>
<td>3. Were there any issues?</td>
<td>Dr. Connolly, Resident Director</td>
<td>Interviews</td>
</tr>
<tr>
<td>4. Have they been addressed?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. What changes have been implemented?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Does the current RRC evaluation review the changes implemented in the program?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Objective 3: By 9/09 Pre and post testing will be developed to evaluate knowledge behavior and attitudes of primary care practice

<table>
<thead>
<tr>
<th>Evaluation Questions</th>
<th>Participant</th>
<th>Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Are pre and post tests being given to the residents?</td>
<td>Dr. Connolly, Resident Director</td>
<td>Interview</td>
</tr>
<tr>
<td>2. What is the percentage of residents that are completing pre and post tests?</td>
<td>Residents</td>
<td>Focus group</td>
</tr>
<tr>
<td>3. What are the scores?</td>
<td>Dr. Connolly, Resident Director</td>
<td>Pre and post test scores</td>
</tr>
<tr>
<td>4. Is there an improvement?</td>
<td>Residents</td>
<td>Focus group</td>
</tr>
<tr>
<td>5. How are the pre and post tests working as a teaching assessment?</td>
<td>Residents</td>
<td>Focus group</td>
</tr>
<tr>
<td>6. Is there a better way to administer the exam?</td>
<td>Dr. Connolly, Resident Director</td>
<td>Review of CREOG scores before and after implementation of the program</td>
</tr>
<tr>
<td>7. Is there an improvement in CREOG scores for preventive care?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The Residency Review Committee already has an evaluation in place to assess the primary and preventive care experience of the residents. In order to develop this evaluation program, we have reviewed the evaluation that the RRC has established, which includes the Resident Experience Report. The RRC’s Resident Experience Report is divided into several sections, one of which is “Primary and Preventive Care Experience Report.” For this report, the resident enters the number of primary care visits under specific categories. They are the following:

1. Hypertension or cardiovascular disease
2. Diabetes mellitus
3. Thyroid disease
4. Dermatological disorders
5. Gastrointestinal disorders
6. Respiratory disorders
7. Breast disorders  
8. Geriatric visit  
9. Behavioral medicine  
10. Immunization  
11. Pediatric/adolescent care  
12. Annual health care maintenance

The data is summarized each year for the American College of Graduate Medical Education at a National Data Report (NDR). The NDR are descriptive statistics that include means, medians, standard deviation, minimum values, maximum values and percentiles. The NDR also provides information about the resident experience nationwide, which is beneficial in establishing national policies for the residents. We have included this evaluation as one component to ensure that residents have adequate exposure to primary care experience.

Additional long-term outcomes may include whether the primary care program affects clinical practice for graduating residents.

Dissemination Plan

Each component of the evaluation will be reviewed by Dr. Fowler and Dr. Connolly to ensure appropriate implementation of the program. The resident director, Dr. Connolly works closely with the chief residents and will receive informal feedback throughout program implementation from the residents. At the completion of the first year of the program, evaluations will assist in the improvement of the primary care program.

After the establishment and evaluation of the primary care program, the program plan will be disseminated to the Residency Review Committee to potentially implement nationally. We plan to share our experiences through presentations at conferences on
teaching, such as APGO, and provide the RRC with a copy of our program plan to
distribute to other residency programs as a model. It is our hope that the program will
improve the training of obstetric and gynecology residents to provide current, evidence-
based primary and preventive care.

Conclusion

Primary care and preventive care are important components of maintaining a
patient’s health. Given that many women see their obstetrician and gynecologist as their
primary care provider, it is important that OB/Gyn residency programs provide the
appropriate education to best prepare the residents to provide evidence-based primary
care. This has been demonstrated to be a priority among the national residency and
examiner organizations, the Residency Review Committee and American Board of
Obstetrics and Gynecology. Additionally, policies have been discussed among the House
of Representatives and the Senate in support of the creation of a medical home for
continuity of care. The national recognition supports that development of the primary
care program is timely.

The primary care program that has been designed for the University of North
Carolina Obstetric and Gynecology program is a simple, reproducible and effective
program that could potentially be implemented in OB/Gyn programs across the nation.
The program combines didactic training and clinical materials to ensure that the patients
receive evidence-based primary and preventive care. This primary and preventive care
program will enable physicians to manage first-line primary care issues and to refer when
appropriate.
The evaluation component will assess the extent to which this program can be utilized at other residency sites. The program has been designed to be reproducible and feasible at other obstetric and gynecology residency programs. The American Board of Obstetrics and Gynecology and the Residency Review Committee have indicated that primary care is vital to the residency education. After the program is implemented at the University of North Carolina, we will work to disseminate our program through the Association of Professors of Obstetrics and Gynecology (APGO). APGO’s mission is to provide “optimal resources and support to educators who inspire, instruct, develop and empower women health care providers of tomorrow.” APGO will be one portal to present the implementation of the primary and preventive care program. We will also disseminate the program description to the Residency Review Committee as they set the standards for educational objectives for residency programs around the country.

It is our hope that this will provide the highest level of primary and preventive care for our patients. We believe that this program will provide trainees with the appropriate education to continue to deliver high quality primary and preventive care to their patients throughout their medical careers.
APPENDIX A.

**Primary and preventive care**

(i) Comprehensive history taking, including medical, nutritional, sexual, family, genetic, and social behavior data, and the ability to assess health risks;

(a) Complete physical examination

(ii) Appropriate use of laboratory studies and diagnostic techniques;

(iii) Patient education and counseling;

(iv) Screening appropriate to patients of various ages and risk factors;

(v) Immunizations needed at specific ages and under specific circumstances;

(vi) Diagnosis and treatment of the common nonreproductive illnesses affecting women;

(vii) Continuous management of the health care of women of all ages;

(viii) Appropriate use of community resources and other physicians through consultation when necessary;

(ix) Appropriate awareness and knowledge of the behavioral and societal factors that influence health among women of differing socioeconomic and cultural backgrounds;

(x) Behavioral medicine and psychosocial problems, including domestic violence, sexual assault, and substance abuse;

(xi) Emergency care;

(xii) Ambulatory primary care problems of the geriatric patient;

(xiii) Basics of epidemiology, statistics, data collection and management, and use of medical literature and assessment of its value;

(xiv) Ethics and medical jurisprudence;

(xv) Community medicine, including health promotion and disease prevention;

(xvi) Health care delivery systems and practice management;

(xvii) Information processing and decision making; and,

(xviii) Patient safety
APPENDIX B.

Office Practice
Preventive Primary Care Blue Print
From The American Board of Obstetrics and Gynecology Bulletin 2007

1. Age-appropriate periodic assessment, preventive care and health maintenance (e.g. mammography, colonoscopy, blood pressure monitoring, hematocrit, immunizations, counseling for proper diet, calcium, folic acid and exercise)

2. Family planning (e.g. contraception, sterilization, complications of pregnancy termination)

3. Life style modification (e.g. smoking cessation, weight loss, substance abuse treatment)

4. Diagnosis and treatment of uncomplicated medical diseases and disorders (e.g. headache, bronchitis, low back pain, irritable bowel, arthritis, acne)

5. Benign breast disorders

6. Urinary tract infections

7. Diabetes mellitus and thyroid disorders

8. Cardiovascular diseases (e.g. hypertension, hyperlipidemia, atherosclerosis)

9. Perimenopause and menopause

10. Osteoporosis

11. Polycystic ovary syndrome

12. Primary and secondary amenorrhea

13. Abnormal uterine bleeding

14. Disorders of reproductive physiology and gynecologic endocrinology (e.g. galactorrhea, hirsutism, anovulation, hyperandrogenism)

15. Early pregnancy loss (e.g. spontaneous abortion, recurrent abortion)

16. Psychiatric conditions (e.g. depression, anxiety)

17. Domestic violence and sexual assault

18. Sexuality and sexual dysfunction
19. Problems relating to physiology of menstruation (e.g. premenstrual syndrome, menstrual migraine, primary dysmenorrhea)

20. Office surgery

21. Vulvar disease (e.g. ulcers, dermatologic conditions, cysts, masses)

22. Vaginal discharge

23. Pediatric and adolescent gynecology

24. Geriatric gynecology

25. Chronic pelvic and vulvar pain

26. Ultrasound

27. Sexually transmitted infections

28. Lesbian health issues

APPENDIX C.

Periodic Assessment Ages 14-18 years

**History**
- Reason for visit
- Health status: medical, menstrual, surgical, family
- Dietary/nutrition assessment
- Physical activity
- Use of complementary and alternative medicine
- Tobacco, alcohol, other drug use
- Abuse/neglect
- Sexual practices

**Physical Examination**
- Height
- Weight
- Body mass index (BMI)
- Blood pressure
- Secondary sexual characteristics
- (Tanner staging)
- Pelvic examination (when indicated by the medical history)
- Skin*

**Laboratory Testing**
- Cervical cytology (annually beginning at approximately 3 years after initiation of sexual intercourse)
- Chlamydia and gonorrhea testing (if sexually active)

**High-Risk Groups***
- Hemoglobin level assessment
- Bacteriuria testing
- Sexually transmitted disease testing

**Human immunodeficiency virus (HIV) testing**
**Genetic testing/counseling**
**Rubella titer assessment**
**Tuberculosis skin testing**
**Lipid profile assessment**
**Fasting glucose testing**
**Hepatitis C virus testing**
**Colorectal cancer screening†**

**Evaluation and Counseling**

**Sexuality**
- Development
- High-risk behaviors
- Preventing unwanted/unintended pregnancy
  --- Postponing sexual involvement
  --- Contraceptive options, including emergency contraception
- Sexually transmitted diseases
  --- Partner selection
  --- Barrier protection

**Fitness and Nutrition**
- Dietary/nutrition assessment (including eating disorders)
- Exercise: discussion of program
- Folic acid supplementation (0.4 mg/d)
- Calcium intake

**Psychosocial Evaluation**
- Suicide: depressive symptoms
- Interpersonal/family relationships
- Sexual identity
- Personal goal development
- Behavioral/learning disorders
- Abuse/neglect
- Satisfactory school experience
- Peer relationships
- Date rape prevention

**Cardiovascular Risk Factors**
- Family history
- Hypertension
- Dyslipidemia
- Obesity
- Diabetes mellitus

**Health/Risk Behaviors**
- Hygiene (including dental), fluoride supplementation*
- Injury prevention
  --- Safety belts and helmets
  --- Recreational hazards
  --- Firearms
  --- Hearing
  --- Occupational hazards
  --- School hazards
- Exercise and sports involvement
- Skin exposure to ultraviolet rays
- Tobacco, alcohol, other drug use
**Immunizations**

Tetanus–diphtheria–pertussis booster (once between ages 11 years and 16 years)

Hepatitis B vaccine (one series for those not previously immunized)

Human papillomavirus vaccine (one series for those not previously immunized)

Meningococcal conjugate vaccine (before entry into high school for those not previously immunized)

**High-Risk Groups***

Influenza vaccine

Hepatitis A vaccine

Pneumococcal vaccine

Measles–mumps–rubella vaccine

Varicella vaccine

---

**Leading Causes of Death‡**

1. Accidents
2. Malignant neoplasms
3. Homicide
4. Suicide
5. Congenital anomalies
6. Diseases of the heart
7. Chronic lower respiratory diseases
8. Influenza and pneumonia
9. Septicemia
10. Pregnancy, childbirth, and puerperium

**Leading Causes of Morbidity‡**

Acne

Asthma

Chlamydia

Headache

Mental disorders, including affective and neurotic disorders

Nose, throat, ear, and upper respiratory infections

Obesity

Sexual assault

Sexually transmitted diseases

Urinary tract infections

Vaginitis

---

*See Table 1.


‡See box.
APPENDIX D. Periodic Assessment-Ages 19-39 years

Screening

History
• Reason for visit
• Health status: medical, surgical, family
• Dietary/nutrition assessment
• Physical activity
• Use of complementary and alternative medicine
• Tobacco, alcohol, other drug use
• Abuse/neglect
• Sexual practices
• Urinary and fecal incontinence

Physical Examination
• Height
• Weight
• Body mass index (BMI)
• Blood pressure
• Neck: adenopathy, thyroid
• Breasts
• Abdomen
• Pelvic examination
• Skin*

Laboratory Testing
• Cervical cytology (annually beginning no later than age 21 years; every 2–3 years after three consecutive negative test results if age 30 years or older with no history of cervical intraepithelial neoplasia 2 or 3, immunosuppression, human immunodeficiency virus [HIV] infection, or diethylstilbestrol exposure in utero)†
• Chlamydia testing (if aged 25 years or younger and sexually active)
• Human Immunodeficiency virus (HIV) testing‡

High-Risk Groups*
• Hemoglobin level assessment
• Bacteriuria testing
• Mammography
• Fasting glucose testing
• Sexually transmitted disease testing
• Genetic testing/counseling
• Rubella titer assessment
• Tuberculosis skin testing
• Lipid profile assessment
• Thyroid-stimulating hormone testing
• Hepatitis C virus testing
• Colorectal cancer screening
• Bone density screening
• Evaluation and Counseling

Sexuality and Reproductive Planning
• High-risk behaviors
• Discussion of a reproductive health plan§
• Contraceptive options for prevention of unwanted pregnancy, including emergency contraception
• Preconception and genetic counseling
• Sexually transmitted diseases
  — Partner selection
  — Barrier protection
• Sexual function

Fitness and Nutrition
• Dietary/nutrition assessment
• Exercise: discussion of program
• Folic acid supplementation (0.4 mg/d)
• Calcium intake

Psychosocial Evaluation
• Interpersonal/family relationships
• Intimate partner violence
• Work satisfaction
• Lifestyle/stress
• Sleep disorders

Cardiovascular Risk Factors
• Family history
• Hypertension
• Dyslipidemia
• Obesity
• Diabetes mellitus
• Lifestyle

Health/Risk Behaviors
• Hygiene (including dental)
• Injury prevention
  — Safety belts and helmets
  — Occupational hazards
  — Recreational hazards
  — Firearms
  — Hearing
—Exercise and sports involvement
- Breast self-examination
- Chemoprophylaxis for breast cancer (for high-risk women aged 35 years or older)
- Skin exposure to ultraviolet rays
- Suicide: depressive symptoms
- Tobacco, alcohol, other drug use

**Immunizations**
- Human papillomavirus vaccine (one series for those aged 26 years or less and not previously immunized)
- Tetanus–diphtheria–pertussis
- Booster (every 10 years)

**High-Risk Groups**
- Measles–mumps–rubella vaccine
- Hepatitis A vaccine
- Hepatitis B vaccine
- Influenza vaccine
- Meningococcal vaccine
- Pneumococcal vaccine
- Varicella vaccine

**Leading Causes of Death**
1. Malignant neoplasms
2. Accidents
3. Diseases of the heart
4. Suicide
5. Human immunodeficiency virus (HIV) disease
6. Homicide
7. Cerebrovascular diseases
8. Diabetes mellitus
9. Chronic liver diseases and cirrhosis
10. Chronic lower respiratory diseases

**Leading Causes of Morbidity**
- Acne
- Arthritis
- Asthma
- Back symptoms
- Cancer
- Chlamydia
- Depression
- Diabetes mellitus
- Gynecologic disorders
- Headache/migraine
- Hypertension
- Joint disorders
- Menstrual disorders
- Mental disorders, including affective and neurotic disorders
- Nose, throat, ear, and upper respiratory infections
- Obesity
- Sexual assault/domestic violence
- Sexually transmitted diseases
- Substance abuse
- Urinary tract infections

*See Table 1.
¶Despite a lack of definite data for or against breast self-examination, breast self-examination has the potential to detect palpable breast cancer and can be recommended.
**See box.
APPENDIX E. Periodic Assessment-Ages 40-64

Screening History
• Reason for visit
• Health status: medical, surgical, family
• Dietary/nutrition assessment
• Physical activity
• Use of complementary and alternative medicine
• Tobacco, alcohol, other drug use
• Abuse/neglect
• Sexual practices
• Urinary and fecal incontinence

Physical Examination
• Height
• Weight
• Body mass index (BMI)
• Blood pressure
• Oral cavity
• Neck: adenopathy, thyroid
• Breasts, axillae
• Abdomen
• Pelvic examination
• Skin*

Laboratory Testing
• Cervical cytology (every 2–3 years after three consecutive negative test
• results if no history of cervical intraepithelial neoplasia 2 or 3, immunosuppression, human immunodeficiency virus [HIV] infection, or diethylstilbestrol exposure in utero)†
• Mammography (every 1–2 years beginning at age 40 years, yearly beginning at age 50 years)
• Lipid profile assessment (every 5 years beginning at age 45 years)
• Colorectal cancer screening (beginning at age 50 years), using one of the following options:
  1. Yearly patient-collected fecal occult blood testing‡
  2. Flexible sigmoidoscopy every 5 years
  3. Yearly patient collected fecal occult blood testing‡ plus flexible sigmoidoscopy every 5 years
  4. Double contrast barium enema every 5 years
  5. Colonoscopy every 10 years
• Fasting glucose testing (every 3 years after age 45 years)
• Thyroid-stimulating hormone screening (every 5 years beginning
  at age 50 years)
• Human immunodeficiency virus
• (HIV) testing§

High-Risk Groups*
• Hemoglobin level assessment
• Bacteriuria testing
• Fasting glucose testing
• Sexually transmitted disease testing
• Tuberculosis skin testing
• Lipid profile assessment
• Thyroid-stimulating hormone testing
• Hepatitis C virus testing
• Colorectal cancer screening

Evaluation and Counseling
Sexuality
• High-risk behaviors
• Contraceptive options for prevention of unwanted pregnancy, including emergency contraception
• Sexually transmitted diseases
—Partner selection
—Barrier protection
• Sexual function

Fitness and Nutrition
• Dietary/nutrition assessment
• Exercise: discussion of program
• Folic acid supplementation (0.4 mg/d before age 50 years)
• Calcium intake

Psychosocial Evaluation
• Family relationships
• Intimate partner violence
• Work satisfaction
• Retirement planning
• Lifestyle/stress
• Sleep disorders

**Cardiovascular Risk Factors**
• Family history
• Hypertension
• Dyslipidemia
• Obesity
• Diabetes mellitus

• Lifestyle

**Health/Risk Behaviors**
• Hygiene (including dental)
• Hormone therapy
• Injury prevention
  — Safety belts and helmets
  — Occupational hazards
  — Recreational hazards
  — Exercise and sports involvement
  — Firearms
  — Hearing
• Breast self-examination
• Chemoprophylaxis for breast cancer (for high-risk women)**
• Skin exposure to ultraviolet rays
• Suicide: depressive symptoms

• Tobacco, alcohol, other drug use

**Immunizations**
• Influenza vaccine
  (annually beginning at age 50 years)
• Tetanus-diphtheria-pertussis booster
  (every 10 years)

**High-Risk Groups**
• Measles–mumps–rubella vaccine
• Hepatitis A vaccine
• Hepatitis B vaccine
• Influenza vaccine
• Meningococcal vaccine
• Pneumococcal vaccine
• Varicella vaccine

**Leading Causes of Death††**
1. Malignant neoplasms
2. Diseases of the heart
3. Cerebrovascular diseases
4. Chronic lower respiratory diseases
5. Accidents
6. Diabetes mellitus
7. Chronic liver disease and cirrhosis
8. Septicemia
9. Suicide
10. Human immunodeficiency virus (HIV) disease

**Leading Causes of Morbidity††**
Arthritis/osteoarthritis
Asthma
Cancer
Cardiovascular disease
Depression
Diabetes mellitus
Disorders of the urinary tract
Headache/migraine
Hypertension
Menopause
Mental disorders, including affective and neurotic disorders
Musculoskeletal symptoms
Nose, throat, ear, and upper respiratory infections
Obesity
Sexually transmitted diseases
Ulcers
Vision impairment

*See Table 1.
‡Fecal occult blood testing (FOBT) requires two or three samples of stool collected by the patient at home and returned for analysis. A single stool sample for FOBT obtained by digital rectal examination is not adequate for the detection of colorectal cancer.
§Physicians should be aware of and follow their states’ HIV screening requirements. For a more detailed discussion of HIV screening, see Branson BM, Handsfield HH, Lampe MA, Janssen RS, Taylor AW, Lyss SB, et al. Revised recommendations for HIV testing of adults,

¶Preconception and genetic counseling is appropriate for certain women in this age group.

¶Despite a lack of definitive data for or against breast self-examination, breast self-examination has the potential to detect palpable breast cancer and can be recommended.


††See box.
APPENDIX F. Periodic Assessment-Ages 65 and older

Screening
History
• Reason for visit
• Health status: medical, surgical, family
• Dietary/nutrition assessment
• Physical activity
• Use of complementary and alternative medicine
• Tobacco, alcohol, other drug use, and concurrent medication use
• Abuse/neglect
• Sexual practices
• Urinary and fecal incontinence

Physical Examination
• Height
• Weight
• Body mass index (BMI)
• Blood pressure
• Oral cavity
• Neck: adenopathy, thyroid
• Breasts, axillae
• Abdomen
• Pelvic examination
• Skin*

Laboratory Testing
• Cervical cytology (every 2–3 years after three consecutive negative test
• results if no history of cervical intraepithelial neoplasia 2 or 3, immunosuppression, human immunodeficiency virus [HIV] infection, or diethylstilbestrol exposure in utero)†
• Urinalysis
• Mammography
• Lipid profile assessment (every 5 years)
• Colorectal cancer screening using one of the following methods:
  1. Yearly patient-collected fecal occult blood testing‡
  2. Flexible sigmoidoscopy every 5 years
  3. Yearly patient collected fecal occult blood testing‡ plus flexible sigmoidoscopy every 5 years
  4. Double contrast barium enema every 5 years
  5. Colonoscopy every 10 years
• Fasting glucose testing (every 3 years)
• Bone density screening§
• Thyroid-stimulating hormone screening (every 5 years)

High-Risk Groups*
• Hemoglobin level assessment
• Sexually transmitted disease testing
• Human immunodeficiency virus
• (HIV) testing
• Tuberculosis skin testing

Evaluation and Counseling
Sexuality
• Sexual function
• Sexual behaviors
• Sexually transmitted diseases
  —Partner selection
  —Barrier protection

Fitness and Nutrition
• Dietary/nutrition assessment
• Exercise: discussion of program
• Calcium intake

Psychosocial Evaluation
• Neglect/abuse
• Lifestyle/stress
• Depression/sleep disorders
• Family relationships
• Work/retirement satisfaction

Cardiovascular Risk Factors
• Hypertension
• Dyslipidemia
• Obesity
• Diabetes mellitus
• Sedentary lifestyle

Health/Risk Behaviors
• Hygiene (including dental)
• Hormone therapy
• Injury prevention
  —Safety belts and helmets
—Prevention of falls
—Occupational hazards
—Recreational hazards
—Exercise and sports involvement
—Firearms
• Visual acuity/glaucoma
• Hearing
• Breast self-examination
• Chemoprophylaxis for breast cancer (for high-risk women)
• Skin exposure to ultraviolet rays
• Suicide: depressive symptoms
• Tobacco, alcohol, other drug use

**Immunizations**
• Tetanus–diphtheria booster (every 10 years)
• Influenza vaccine (annually)
• Pneumococcal vaccine (once)

**Leading Causes of Death**
1. Diseases of the heart
2. Malignant neoplasms
3. Cerebrovascular diseases
4. Chronic lower respiratory diseases
5. Alzheimer’s disease
6. Influenza and pneumonia
7. Diabetes mellitus
8. Nephritis, nephrotic syndrome, and nephrosis
9. Accidents
10. Septicemia

**Leading Causes of Morbidity**
Arthritis/osteoarthritis
Asthma
Cancer
Cardiovascular disease
Chronic obstructive pulmonary diseases
Diabetes mellitus
Diseases of the nervous system and sense organs
Hearing and vision impairment
Hypertension
Mental disorders
Musculoskeletal symptoms
Nose, throat, ear, and upper respiratory infections
Obesity
Osteoporosis
Pneumonia
Ulcers
Urinary incontinence
Urinary tract infections
Vertigo

High-Risk Groups*
• Hepatitis A vaccine
• Hepatitis B vaccine
• Meningococcal vaccine
• Varicella vaccine
*See Table 1.
‡Fecal occult blood testing (FOBT) requires two or three samples of stool collected by the patient at home and returned for analysis. A single stool sample for FOBT obtained by digital rectal examination is not adequate for detection of colorectal cancer.
§In the absence of new risk factors, subsequent bone density screening should not be performed more frequently than every 2 years.
¶Despite a lack of definitive data for or against breast self-examination, breast self-examination has the potential to detect palpable breast cancer and can be recommended.
**See box.
APPENDIX G. United States Preventive Services Task Force Recommendations

Adult Preventive Care Timeline

**Women < 40 years old (yo)**

<table>
<thead>
<tr>
<th>SBP at least q 2 years</th>
<th>&gt;/= 18 yo</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chlamydia/Gonorhea screening</td>
<td>18-25 yo, &gt;/= 26 yo if high risk</td>
</tr>
<tr>
<td>Cholesterol</td>
<td>Only those at risk for CAD (DM, FHx of CAD before 50 yo in males and before 60 yo in females, multiple CAD risk factors’s, FHx of familial hyperlipidemia), q 5 years if normal</td>
</tr>
<tr>
<td>Depression screening</td>
<td>&gt;/= 18 yo</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Only at risk for CAD (HTN or hyperlipidemia)</td>
</tr>
<tr>
<td>HIV/Syphilis screening</td>
<td>At risk &gt; 18 yo</td>
</tr>
<tr>
<td>Influenza vaccine</td>
<td>18-65 yo if at risk</td>
</tr>
<tr>
<td>Obesity screening (BMI)</td>
<td>Offer intensive counseling and behavioral interventions with BMI &gt;/= 30</td>
</tr>
<tr>
<td>Pap smear</td>
<td>3 yrs after onset of sexual activity or 21 yo</td>
</tr>
</tbody>
</table>

* Based on A or B recommendation from the USPTF

**Women >/= 40 yo**

<table>
<thead>
<tr>
<th>ASA to prevent MI</th>
<th>&gt;/= 50 yo (postmenopausal women)</th>
</tr>
</thead>
<tbody>
<tr>
<td>BP at least q 2 years</td>
<td>&gt;/= 18 yo</td>
</tr>
<tr>
<td>Cholesterol screening (total cholesterol and HDL-C)</td>
<td>&gt;/= 45 yo, q 5 years if normal</td>
</tr>
<tr>
<td>Colorectal Screening</td>
<td>&gt;/= 50 yo</td>
</tr>
<tr>
<td>Depression screening</td>
<td>&gt;/= 18 yo</td>
</tr>
<tr>
<td>Diet</td>
<td>High cholesterol and those at risk of DM and CAD</td>
</tr>
<tr>
<td>---------------------------</td>
<td>--------------------------------------------------</td>
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<tr>
<td>Mammogram</td>
<td>&gt;= 40 yo q 1-2 yrs</td>
</tr>
<tr>
<td>Influenza vaccine</td>
<td>&gt;= 65 q year</td>
</tr>
<tr>
<td>Pap smear</td>
<td>At least q 3 yrs until 65 yo</td>
</tr>
<tr>
<td>Pneumococcal vaccine</td>
<td>&gt;/65 yo</td>
</tr>
<tr>
<td>Obesity screening (BMI)</td>
<td>Offer intensive counseling and behavioral interventions with BMI &gt;= 30</td>
</tr>
<tr>
<td>Osteoporosis screening</td>
<td>60-65 yo if at risk (wt less than 70 kg and no current HRT), &gt;= 65 yo</td>
</tr>
<tr>
<td>Tobacco use/ Alcohol misuse</td>
<td>&gt;= 18 yo</td>
</tr>
</tbody>
</table>

* Based on A or B recommendation from the USPTF

**Insufficient evidence:**
- Clinical breast exam/ self breast exam
- Multivitamin supplementation (except for folic acid for women who are “planning, or capable of, pregnancy.”
- Screening for family and intimate partner violence
- Screening for thyroid disease
- Screening asymptomatic adults for type 2 DM

**Reference:**
APPENDIX H. Initial Visit Intake Forms in English and Spanish
(see subsequent pages)
Patient History Form

Name: ___________________________ Age: ______

Race: ☐ White ☐ Black ☐ Hispanic/ Latina ☐ Asian/Pacific Islander ☐ Other_____________

Are you allergic to anything? ☐ No ☐ Yes → Please list your allergies ________________________________

Please list all medications you are taking, both prescription and over the counter.

<table>
<thead>
<tr>
<th>Name of medicine</th>
<th>Dose</th>
<th>How often do you take it?</th>
<th>When did you last take it?</th>
<th>Why are you taking it?</th>
<th>For how long have you been taking it?</th>
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</tbody>
</table>

☐ Reviewed by MD ______________________________________________ signature

Today’s Visit:

What is the main reason you came to the clinic today? ____________________________________________________

_______________________________________________________________________________________________

When did it start? ________________________________________________________________

What treatments have you had so far for this health issue? ____________________________________________

Preventive history:

When did you have your last tetanus shot? __________________________________________

Have you had chicken pox? ☐ No ☐ Yes → When? __________________________

Have you been vaccinated for pneumococcus? ☐ No ☐ Yes → When? ________________

(That is, have you had a “pneumonia shot”)

Have you ever had a bone scan or BMD scan? ☐ No ☐ Yes → When? ________________

If you are 40 years of age or older, please answer the following questions:

Have you had a colonoscopy or sigmoidoscopy? ☐ No ☐ Yes ⇒ When? __________

Have you had a mammogram? ☐ No ☐ Yes ⇒ When? __________

Have you been vaccinated for pneumococcus? ☐ No ☐ Yes ⇒ When? __________

(That is, have you had a “pneumonia shot”)

For Med Personnel only:

BP: /
Pulse:
Pulse ox:
Temp:
Ht:
Wt:
BMI:
Pain rating:
Smoking: Y / N

56 /70
Past Surgical and Hospitalization History:
List all previous surgeries (type and date):

____________________________________________________________________________________________

List all hospitalizations (reason and date)?

____________________________________________________________________________________________

Have you ever had a blood transfusion? □ No □ Yes

Past Medical History:
Please check any of the following illnesses you have ever had.

☐ Bleeding problems (easy bruising, easy bleeding, heavy menses) ☐ Neurological problems (Seizure, migraine headaches)

☐ Clotting problems (Deep Vein Thrombosis, pulmonary embolus) ☐ Psychological/Psychiatric problems (depression, bipolar disorder, schizophrenia)

☐ High blood pressure (hypertension) ☐ Tuberculosis

☐ Heart Problems ☐ Lung problems (asthma, pneumonia)

☐ Kidney/Urine problems ☐ Liver problems (including hepatitis)

☐ HIV/AIDS ☐ Thyroid problems

☐ Cancer (list type) _______________ ☐ Other ______________________________

Past Obstetrical History:
How many times have you been pregnant? _____
Of these pregnancies, how many were...

preterm (premature) deliveries? _____
full term deliveries? _____
miscarriages? _____
abortions? _____

Have you had a cesarean section for any of your deliveries? □ No □ Yes

Past Gynecological History:
What was the first day of your last menstrual period? ___________________
Are you using contraception? □ No □ Yes □ Not sexually active
If yes, what type (check all that apply)? □ birth control pills □ condoms □ rhythm method
☐ depo provera (the shot) ☐ nuva ring ☐ withdrawal/"pull out"
☐ IUD ☐ sterilization (vasectomy or tubal ligation) "tubes tied"

Please check any of the following that you have ever had.

☐ Heavy menstruation ☐ Fibroids (myomas)

☐ Irregular bleeding ☐ Sexually transmitted infection (gonorrhea, chlamydia, herpes)
Abnormal pap smear □ Pelvic infection (PID) □ Other: ______________

Ovarian cysts or tumors

Family History:
Which, if any, of your relatives had had or died from any of the following illnesses?
- Diabetes □ No □ Yes ⇒ Who? ___________________________________________
- Stroke □ No □ Yes ⇒ Who? ___________________________________________
- Asthma □ No □ Yes ⇒ Who? ___________________________________________
- Cancer □ No □ Yes ⇒ Who? ___________________________________________ What type?________________
- Migraine headaches □ No □ Yes ⇒ Who? ___________________________________________
- Hypertension □ No □ Yes ⇒ Who? _________________________________________
- Heart Disease □ No □ Yes ⇒ Who? _________________________________________
- Kidney problems □ No □ Yes ⇒ Who? _______________________________________
- Mental disease □ No □ Yes ⇒ Who? _________________________________________
- Disease of the Cervix □ No □ Yes ⇒ Who? _________________________________
- Disease of the Ovary □ No □ Yes ⇒ Who? _________________________________
- Disease of the Uterus □ No □ Yes ⇒ Who? _________________________________

Social History:
Are you? □ Single □ Married □ Divorced □ Widowed
Who do you live with? ________________________________________________
Do you work now? □ Yes □ No
What is your current or most recent job? ________________________________
What is the highest level of education you have completed?
□ < 5th grade □ 6th-9th grade □ Some high school □ Graduated high school
□ Some college □ Completed college □ Graduate school
Do you drink alcohol? □ No □ Yes ⇒ When was the last time you had more than 4 drinks in one day?
□ Never □ In the past 3 months □ Over 3 months ago
Do you smoke? □ No □ Yes ⇒ How often? _________________________________
Do you use any other drugs? □ No □ Yes ⇒ What are they? _________________
Do you exercise? □ No □ Yes ⇒ How often? _________________________________
Do you wear your seat belt? □ No □ Yes
Do you take a multivitamin? □ No □ Yes
Do you use sunblock? □ No □ Yes
Do you have 5 servings of fruit and vegetables a day? □ No □ Yes
During the past month:
  Have you been bothered by feeling down, depressed or hopeless? □ No □ Yes
  Have you often been bothered by little interest or pleasure in doing things? □ No □ Yes
Have you been hit, kicked, punched or otherwise hurt by someone in the past year?  
[ ] No [ ] Yes  
Do you feel safe in your current relationship?  
[ ] No [ ] Yes  
Is there a partner from a previous relationship who is making you feel unsafe now?  
[ ] No [ ] Yes  

Please indicate whether each of the following is currently a concern for you.

<table>
<thead>
<tr>
<th>General</th>
<th>Skin</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excessive fatigue</td>
<td>Skin rash</td>
</tr>
<tr>
<td>Weight loss</td>
<td>Recurrent sores</td>
</tr>
<tr>
<td>Excessive thirst</td>
<td>Moles that have changed in color or size</td>
</tr>
<tr>
<td>Feeling abnormally hot or cold</td>
<td>Swollen glands</td>
</tr>
<tr>
<td>Lumps or swelling</td>
<td>Itching</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Eye, Ear, Nose &amp; Mouth</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Hearing difficulty</td>
<td></td>
</tr>
<tr>
<td>Ringing in the ear</td>
<td></td>
</tr>
<tr>
<td>Changes in vision</td>
<td></td>
</tr>
<tr>
<td>Change in voice</td>
<td></td>
</tr>
<tr>
<td>Difficulty swallowing</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Breasts</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Lumps</td>
<td></td>
</tr>
<tr>
<td>Tenderness</td>
<td></td>
</tr>
<tr>
<td>Swelling</td>
<td></td>
</tr>
<tr>
<td>Nipple discharge</td>
<td></td>
</tr>
<tr>
<td>Skin changes/rash</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Musculoskeletal</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Swollen or painful joints</td>
<td></td>
</tr>
<tr>
<td>Neck pain</td>
<td></td>
</tr>
<tr>
<td>Severe leg cramps</td>
<td></td>
</tr>
<tr>
<td>Back pain or injury</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Lungs</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Short of breath</td>
<td></td>
</tr>
<tr>
<td>Cough</td>
<td></td>
</tr>
<tr>
<td>Wheezing</td>
<td></td>
</tr>
<tr>
<td>Coughing up blood</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Gastrointestinal</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor appetite</td>
<td></td>
</tr>
<tr>
<td>Frequent nausea and/ or vomiting</td>
<td></td>
</tr>
<tr>
<td>Heartburn</td>
<td></td>
</tr>
<tr>
<td>Black tarry stool</td>
<td></td>
</tr>
<tr>
<td>Constipation</td>
<td></td>
</tr>
<tr>
<td>Diarrhea</td>
<td></td>
</tr>
<tr>
<td>Blood in stool</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Gynecological</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Heavy bleeding</td>
<td></td>
</tr>
<tr>
<td>Bleeding between periods</td>
<td></td>
</tr>
<tr>
<td>Irregular bleeding</td>
<td></td>
</tr>
<tr>
<td>Severe cramps with period</td>
<td></td>
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<tr>
<td>Pelvic Pain</td>
<td></td>
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<tr>
<td>Sores or ulcers</td>
<td></td>
</tr>
<tr>
<td>Vaginal discharge</td>
<td></td>
</tr>
<tr>
<td>Foul smelling odor</td>
<td></td>
</tr>
<tr>
<td>Pain after sex</td>
<td></td>
</tr>
<tr>
<td>Bleeding after sex</td>
<td></td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Urinary</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Pain when urinating</td>
<td></td>
</tr>
<tr>
<td>Excessive urinating at night</td>
<td></td>
</tr>
<tr>
<td>Bladder infections</td>
<td></td>
</tr>
<tr>
<td>Leakage of urine</td>
<td></td>
</tr>
<tr>
<td>Kidney stones</td>
<td></td>
</tr>
</tbody>
</table>
Formulario de la Historia de la Paciente
(Patient History Form)

Nombre: __________________________________________     Edad: ________

Raza:  □ Blanca (caucásica) □ Negra □ Hispana/ Latina □ Asiática/ Islas del Pacífico □ Otra_____

¿Es usted alérgica a algo? □ No □ Sí → Por favor liste sus alergias__________________________

Por favor liste todos los medicamentos que está tomando, ambos recetados y sin receta.

<table>
<thead>
<tr>
<th>Nombre del medicamento</th>
<th>Dosis</th>
<th>¿Con qué frecuencia lo toma?</th>
<th>¿Cuando fue la última vez que lo tomó?</th>
<th>¿Por qué lo toma?</th>
<th>¿Por cuánto tiempo lo ha estado tomando?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

□ Reviewed by MD ______________________________________________ signature

Visita de Hoy:
¿Cuál es la razón principal por la cual vino a la clínica hoy? ______________________________________________
___________________________________________________________________________________________

¿Cuándo comenzó esto? ________________________________________________________

¿Qué tratamiento ha recibido hasta ahora para este problema de salud? __________________________

_____________________________________________________________________________

Historia Preventiva:
¿Cuándo fue su última vacuna contra el tétano? __________________________

¿Ha tenido varicela? □ No □ Sí → ¿Cuándo? __________________________

¿Ha recibido la vacuna contra la varicela? □ No □ Sí

Si usted tiene 40 años o más, por favor conteste las siguientes preguntas:

¿Le han hecho una colonoscopía o sigmoidoscopía? □ No □ Sí ⇒ ¿Cuándo? ______

¿Le han hecho una mamografía? □ No □ Sí ⇒ ¿Cuándo? ______

¿Ha sido vacunada para neumococo? □ No □ Sí ⇒ ¿Cuándo? ______

(esto es, ha recibido la vacuna contra la neumonía (pulmonía))

¿Alguna vez le han hecho una prueba de densidad ósea? □ No □ Sí ⇒ ¿Cuándo? ______
Historia Quirúrgica Pasada y Hospitalizaciones:
Haga una lista de todas las cirugías previas (tipo y fecha): __________________________________________________________

Haga una lista de todas las hospitalizaciones (razón y fecha): __________________________________________________________

¿Alguna vez ha recibido una transfusión de sangre? ☐ No ☐ Sí

Historia Médica Pasada:
Por favor marque cualquiera de las siguientes enfermedades que usted haya tenido.

☐ Problemas de sangrado (se le forman moretones fácilmente, sangra fácilmente, periodos abundantes) ☐ Problemas neurológicos (ataques/convulsiones, migrañas)
☐ Problemas de coagulación (Trombosis Venosa Profunda, embolo pulmonar) ☐ Problemas psicológicos/psiquiátricos (depresión, trastorno bipolar, esquizofrenia)
☐ Presión arterial alta (hipertensión) ☐ Tuberculosis
☐ Problemas Cardíacos (corazón) ☐ Problemas Pulmonares/pulmones (asma, neumonía)
☐ Problemas Renales (riñón/orina) ☐ Problemas Hepáticos/hígado (incluyendo hepatitis)
☐ VIH/SIDA ☐ Problemas de la Tiroides
☐ Cáncer (tipo) _____________ ☐ Otro ______________________________

Historia Obstétrica Pasada:
¿Cuántas veces ha estado embarazada? _____
De estos embarazos, ¿cuántos fueron…
partos prematuros (antes de tiempo)? _____
partos a término? _____
abortos espontáneos? _____
abortos? _____
¿Tuvo usted una cesárea para alguno de estos embarazos? ☐ No ☐ Sí

Historia Ginecológica Pasada:
¿Cuándo fue el primer día de su último periodo? _______________________

¿Esta usted usando anticonceptivos? ☐ No ☐ Sí ☐ No estoy sexualmente activa
Si contestó “Sí”, ¿que tipo? (marque todo lo que aplica) ☐ anticonceptivos orales ☐ condones ☐ método del ritmo
depo provera (inyección) ☐ anillo vaginal (NuvaRing) ☐ retiro
dispositivo intrauterino ☐ esterilización (vasectomía o ligadura de trompas)

Por favor marque cualquiera de los siguientes que usted haya tenido.
☐ Menstruaciones abundantes ☐ Fibroides (miomas)
☐ Sangrados irregulares ☐ Infecciones transmitidas sexualmente (gonorrea, clamidia, herpes)
☐ Papamiconau anormal ☐ Infección pélvica/Enfermedad Inflamatoria Pélvica (EIP)
☐ Quistes o tumores de ovarios ☐ Otro: ______________________
### Historia Familiar:

¿Cuál, si alguno, de sus familiares ha padecido o muerto de alguna de las siguientes enfermedades?

<table>
<thead>
<tr>
<th>Enfermedad</th>
<th>No</th>
<th>Sí</th>
<th>¿Quién?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Derrame</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Asma</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cáncer</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Migraña</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hipertensión</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Enfermedad cardíaca</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Problemas renales</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enfermedad mental</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Enfermedad del cuello uterino</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enfermedad del ovario</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enfermedad del útero</td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

### Historia Social:

<table>
<thead>
<tr>
<th>¿Esta usted?</th>
<th>Soltera</th>
<th>Casada</th>
<th>Divorciada</th>
<th>Viuda</th>
</tr>
</thead>
<tbody>
<tr>
<td>¿Con quién vive usted?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>¿Esta usted trabajando ahora?</th>
<th>Sí</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>¿Cuál es su trabajo actual o más reciente?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>¿Cuál es el nivel más alto de educación que usted ha completado?</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Si</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 5º grado</td>
<td>6º-9º grado</td>
</tr>
<tr>
<td>Parte de la universidad</td>
<td>Completó la universidad</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>¿Toma usted alcohol?</th>
<th>No</th>
<th>Sí</th>
<th>¿Cuándo fue la última vez que tomó mas de 4 tragos en un día?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Nunca</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>¿Usted fuma?</th>
<th>No</th>
<th>Sí</th>
<th>¿Con qué frecuencia?</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>¿Usa alguna otra droga?</th>
<th>No</th>
<th>Sí</th>
<th>¿Cuáles?</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>¿Hace ejercicios?</th>
<th>No</th>
<th>Sí</th>
<th>¿Con qué frecuencia?</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>¿Usted usa el cinturón de seguridad?</th>
<th>No</th>
<th>Sí</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>¿Se toma usted una multi-vitamina?</th>
<th>No</th>
<th>Sí</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>¿Usa bloqueador solar?</th>
<th>No</th>
<th>Sí</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>¿Consume usted 5 porciones de fruta y vegetales al día?</th>
<th>No</th>
<th>Sí</th>
</tr>
</thead>
</table>

| Durante el mes pasado: |

<table>
<thead>
<tr>
<th>¿Se ha sentido decaído, deprimida o sin esperanzas?</th>
<th>No</th>
<th>Sí</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>¿Con qué frecuencia se siente molesta por tener poco interés o placer en hacer cosas?</th>
<th>No</th>
<th>Sí</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>¿Ha sido golpeada, pateada o lastimada de alguna otra forma por alguien en el último año?</th>
<th>No</th>
<th>Sí</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>¿Se siente usted segura en su relación actual?</th>
<th>No</th>
<th>Sí</th>
</tr>
</thead>
</table>

| ¿Hay alguna pareja de una relación previa quien la esta haciendo sentir amenazada? | No | Sí |
Por favor indique si alguna de las siguientes la está preocupando actualmente.

<table>
<thead>
<tr>
<th>General</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Fatiga excesiva</td>
<td>No</td>
</tr>
<tr>
<td>Pérdida de peso</td>
<td>No</td>
</tr>
<tr>
<td>Sed excesiva</td>
<td>No</td>
</tr>
<tr>
<td>Sentirse anormalmente con calor o frío</td>
<td>No</td>
</tr>
<tr>
<td>Bultos o hinchazón</td>
<td>No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>General</th>
<th></th>
</tr>
</thead>
<tbody>
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<td></td>
</tr>
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<td>No</td>
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</tr>
<tr>
<td>Bultos o hinchazón</td>
<td>No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ojo, Oído, Nariz y Boca</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Dificultad para escuchar</td>
<td>No</td>
</tr>
<tr>
<td>Zumbido en el oído</td>
<td>No</td>
</tr>
<tr>
<td>Cambios en la visión</td>
<td>No</td>
</tr>
<tr>
<td>Cambios en la voz</td>
<td>No</td>
</tr>
<tr>
<td>Dificultad para tragar</td>
<td>No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
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<th></th>
</tr>
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<tr>
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</tr>
<tr>
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<td>No</td>
</tr>
<tr>
<td>Dificultad para tragar</td>
<td>No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Musculoesquelético</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Articulaciones hinchadas y dolorosas</td>
<td>No</td>
</tr>
<tr>
<td>Dolor de cuello</td>
<td>No</td>
</tr>
<tr>
<td>Calambres severos en las piernas</td>
<td>No</td>
</tr>
<tr>
<td>Dolor de espalda o daño</td>
<td>No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Musculoesquelético</th>
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</thead>
<tbody>
<tr>
<td>Articulaciones hinchadas y dolorosas</td>
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<td>No</td>
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<td>No</td>
</tr>
<tr>
<td>Dolor de espalda o daño</td>
<td>No</td>
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<table>
<thead>
<tr>
<th>Pulmones</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Falta de respiración</td>
<td>No</td>
</tr>
<tr>
<td>Tos</td>
<td>No</td>
</tr>
<tr>
<td>Respiración sibilante</td>
<td>No</td>
</tr>
<tr>
<td>Tosiendo con sangre</td>
<td>No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pulmones</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Falta de respiración</td>
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</tr>
<tr>
<td>Tos</td>
<td>No</td>
</tr>
<tr>
<td>Respiración sibilante</td>
<td>No</td>
</tr>
<tr>
<td>Tosiendo con sangre</td>
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<table>
<thead>
<tr>
<th>Gastrointestinal</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Poco apetito</td>
<td>No</td>
</tr>
<tr>
<td>Nauseas frecuentes y/o vomitos</td>
<td>No</td>
</tr>
<tr>
<td>Acidez estomacal</td>
<td>No</td>
</tr>
<tr>
<td>Excremento negro alquitranado</td>
<td>No</td>
</tr>
<tr>
<td>Estreñimiento</td>
<td>No</td>
</tr>
<tr>
<td>Diarrea</td>
<td>No</td>
</tr>
<tr>
<td>Sangre en el excremento</td>
<td>No</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Gastrointestinal</th>
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</tr>
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<tbody>
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<tr>
<td>Estreñimiento</td>
<td>No</td>
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<td>No</td>
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<tr>
<td>Sangre en el excremento</td>
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<table>
<thead>
<tr>
<th>Piel</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Salpullido</td>
<td>No</td>
</tr>
<tr>
<td>Ulceras/llagas reocurrentes</td>
<td>No</td>
</tr>
<tr>
<td>Lunares que han cambiado de color o tamaño</td>
<td>No</td>
</tr>
<tr>
<td>Glándulas hichadas</td>
<td>No</td>
</tr>
<tr>
<td>Picazón</td>
<td>No</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Piel</th>
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<tr>
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</thead>
<tbody>
<tr>
<td>Dolores de cabeza frecuentes y severos</td>
<td>No</td>
</tr>
<tr>
<td>Mareos</td>
<td>No</td>
</tr>
<tr>
<td>Desmallos</td>
<td>No</td>
</tr>
<tr>
<td>Adormecimiento y hormigueo reocurrente en las manos y los pies</td>
<td>No</td>
</tr>
<tr>
<td>Cambios de ánimo, irritabilidad</td>
<td>No</td>
</tr>
<tr>
<td>Depresión o ansiedad</td>
<td>No</td>
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<table>
<thead>
<tr>
<th>Sistema Nervioso</th>
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<tr>
<td>Dolores de cabeza frecuentes y severos</td>
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<tr>
<td>Depresión o ansiedad</td>
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<table>
<thead>
<tr>
<th>Ginecológico</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Sangrado abundante</td>
<td>No</td>
</tr>
<tr>
<td>Sangrado entre periodos</td>
<td>No</td>
</tr>
<tr>
<td>Sangrado irregular</td>
<td>No</td>
</tr>
<tr>
<td>Calambres severos con el periodo</td>
<td>No</td>
</tr>
<tr>
<td>Dolor pélvico</td>
<td>No</td>
</tr>
<tr>
<td>Llagas o úlceras</td>
<td>No</td>
</tr>
<tr>
<td>Secreción/flujo vaginal</td>
<td>No</td>
</tr>
<tr>
<td>Olor repugnante/maloliente</td>
<td>No</td>
</tr>
<tr>
<td>Dolor después de tener relaciones</td>
<td>No</td>
</tr>
<tr>
<td>Sangrado después de tener relaciones</td>
<td>No</td>
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<table>
<thead>
<tr>
<th>Ginecológico</th>
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</thead>
<tbody>
<tr>
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<tr>
<td>Sangrado entre periodos</td>
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<td>Sangrado irregular</td>
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<tr>
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</tr>
<tr>
<td>Dolor después de tener relaciones</td>
<td>No</td>
</tr>
<tr>
<td>Sangrado después de tener relaciones</td>
<td>No</td>
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<table>
<thead>
<tr>
<th>Urinario</th>
<th></th>
</tr>
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<tbody>
<tr>
<td>Dolor al orinar</td>
<td>No</td>
</tr>
<tr>
<td>Orinar excesivamente durante la noche</td>
<td>No</td>
</tr>
<tr>
<td>Infecciones de la vejiga</td>
<td>No</td>
</tr>
<tr>
<td>Escape de orina</td>
<td>No</td>
</tr>
<tr>
<td>Cálculos renales/piedras en el riñón</td>
<td>No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Urinario</th>
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<td>No</td>
</tr>
<tr>
<td>Cálculos renales/piedras en el riñón</td>
<td>No</td>
</tr>
</tbody>
</table>

Translated by Lizzette Vega, UNC Healthcare Spanish Interpreter – 02/06/08
**Patient History Update**

Name: __________________________ Date: ______

1. What is the main reason you came to the clinic today? __________________________

2. Have you been seriously ill since your last visit?  ☐ No  ☐ Yes ⇒ Explain: ________________

3. What medications are you taking regularly? Include prescriptions and all over-the-counter drugs, such as vitamins, calcium, aspirin, etc. (List name and dosage.)

   __________________________

   __________________________

   __________________________

4. What medications are you allergic to?

   __________________________

5. Do you use tobacco in any form?  ☐ No  ☐ Yes

6. How much alcohol do you consume? __________________________

7. Have you had a colonoscopy or sigmoidoscopy?  ☐ No  ☐ Yes ⇒ When? ______

8. Have you had a mammogram?  ☐ No  ☐ Yes ⇒ When? ______

9. Have you been vaccinated for pneumococcus?  ☐ No  ☐ Yes ⇒ When? ______
   (that is, have you had a “pneumonia shot”)

10. Have you ever had a bone scan or BMD scan?  ☐ No  ☐ Yes ⇒ When? ______

11. Have your parents or siblings developed any significant health problems since your last visit?  ☐ No  ☐ Yes ⇒ Explain: __________________________

12. Do you wear seat belts all the time?  ☐ No  ☐ Yes

13. Do you exercise on a regular basis?  ☐ No  ☐ Yes

14. Do you have pain, either acute or chronic?  ☐ No  ☐ Yes ⇒ Explain: __________________________

15. Have you been physically, emotionally or verbally abused by someone in the past year?  ☐ No  ☐ Yes

16. Are you having any of the following symptoms? (Please circle)

<table>
<thead>
<tr>
<th>Headaches</th>
<th>High Blood Pressure</th>
<th>Back Pain</th>
<th>Sleep Problems</th>
</tr>
</thead>
<tbody>
<tr>
<td>Double Vision</td>
<td>Weight Gain or Loss</td>
<td>Painful or Swollen Joints</td>
<td>Memory Loss</td>
</tr>
<tr>
<td>Blurred Vision</td>
<td>Recurrent Abdominal Pain</td>
<td>Muscle Weakness</td>
<td>Depression</td>
</tr>
<tr>
<td>Dizziness</td>
<td>Recurrent Indigestion</td>
<td>Numbness</td>
<td>Thoughts of Suicide</td>
</tr>
<tr>
<td>Hearing Problems</td>
<td>Rectal Bleeding</td>
<td>Coordination Problems</td>
<td>Rash</td>
</tr>
<tr>
<td>Hay Fever</td>
<td>Constipation</td>
<td>Bleeding or Bruising</td>
<td>Hair Loss</td>
</tr>
<tr>
<td>Sinus Problems</td>
<td>Change in Bowel Habit</td>
<td>Anemia</td>
<td>Dry Skin</td>
</tr>
<tr>
<td>Hoarseness</td>
<td>Black Stools</td>
<td>Breast Lumps</td>
<td>Changes in Moles</td>
</tr>
<tr>
<td>Shortness of Breath</td>
<td>Difficulty with Urination</td>
<td>Cold or Heat Intolerance</td>
<td>Hot Flashes</td>
</tr>
<tr>
<td>Chronic Cough</td>
<td>Blood in the Urine</td>
<td>Frequent/Painful Periods</td>
<td>Unusual Thirst</td>
</tr>
</tbody>
</table>

For Med Personnel only:

BP: ______ / ______

Pulse:

Pulse ox:

Temp:

Ht:

Wt:

BMI:

Pain rating:

Smoking: Y / N
<table>
<thead>
<tr>
<th>Coughing Up Blood</th>
<th>Sexual Problems</th>
<th>Night Sweats</th>
<th>Frightening Dreams</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rapid/Irregular Heart Beat</td>
<td>Chest Pain or Pressure</td>
<td>Chronic Job or Family Stress</td>
<td>Fever</td>
</tr>
</tbody>
</table>
Actualización de la Historia del Paciente
Nombre: ___________________________________          Fecha: _______

17. ¿Cuál es la razón principal para venir a la clínica hoy? _____________________________________

18. ¿Ha estado seriamente enferma desde la última visita?  ☐ No  ☐ Sí ⇒ Explique: ____________________________

19. ¿Qué medicamentos está tomando regularmente? Incluya todos los medicamentos recetados, sin receta, tales como vitaminas, calcio, aspirina, etc. (haga una lista con nombre y dosis.)

________________________________     __________________________________     ____________________________
________________________________     __________________________________     ____________________________
________________________________     __________________________________     ____________________________

20. ¿A qué medicamentos es usted alérgica?
________________________________     __________________________________

21. ¿Usa alguna forma de tabaco?  ☐ No  ☐ Sí

22. ¿Cuánto alcohol consume usted? ____________________________________________

23. ¿Le han hecho una colonoscopía o sigmoidoscopía?  ☐ No  ☐ Sí ⇒ ¿Cuándo? __________

24. ¿Le han hecho una mamografía?  ☐ No  ☐ Sí ⇒ ¿Cuándo? __________

25. ¿Ha sido vacunada para neumocoque?  ☐ No  ☐ Sí ⇒ ¿Cuándo? __________
   (esto es, ha recibido la vacuna contra la neumonía)

26. ¿Le han hecho una prueba de la densidad ósea?  ☐ No  ☐ Sí ⇒ ¿Cuándo? __________

27. ¿Han desarrollado sus padres o hermanos algún problema de salud significativo desde su última visita?  ☐ No  ☐ Sí ⇒ Explique: __________________________

28. ¿Usa el cinturón de seguridad todo el tiempo?  ☐ No  ☐ Sí

29. ¿Hace usted ejercicios regularmente?  ☐ No  ☐ Sí

30. ¿Tiene dolor, ya sea agudo o crónico?  ☐ No  ☐ Sí ⇒ Explique: ____________________________

31. ¿Ha sido usted abusada física, emocional o verbalmente por alguien en el último año?  ☐ No  ☐ Sí

32. ¿Quién es su médico de cabecera? ________________________________

33. ¿Está usted teniendo alguno de estos síntomas? (Por favor circule)

<table>
<thead>
<tr>
<th>Dolores de cabeza</th>
<th>Presión Arterial Alta</th>
<th>Dolor de Espalda</th>
<th>Problemas para Dormir</th>
</tr>
</thead>
<tbody>
<tr>
<td>Visión Doble</td>
<td>Ganancia o Pérdida de Peso</td>
<td>Articulaciones Dolorosas o Hinchadas</td>
<td>Pérdida de Memoria</td>
</tr>
<tr>
<td>Visión Borrosa</td>
<td>Dolor Abdominal Reocurrente</td>
<td>Debilidad Muscular</td>
<td>Depresión</td>
</tr>
<tr>
<td>Mareos</td>
<td>Indigestión Reocurrente</td>
<td>Adormecimiento</td>
<td>Pensamientos de Suicidio</td>
</tr>
<tr>
<td>Problemas de Audición</td>
<td>Sangrado Rectal</td>
<td>Problemas de Coordinación</td>
<td>Salpullido</td>
</tr>
<tr>
<td>Fiebre del Heno</td>
<td>Estreñimiento</td>
<td>Sangrado o Moretones</td>
<td>Pérdida de cabello</td>
</tr>
<tr>
<td>Problemas de los senos paranasales</td>
<td>Cambio en el Hábito Intestinal</td>
<td>Anemia</td>
<td>Piel Seca</td>
</tr>
<tr>
<td>Ronquera</td>
<td>Excremento Negro</td>
<td>Bultos en los Senos</td>
<td>Cambios en los Lunares</td>
</tr>
<tr>
<td>Falta de Respiración</td>
<td>Dificultad al Orinar</td>
<td>Intolerancia al Calor o Frío</td>
<td>Calores Repentinos</td>
</tr>
<tr>
<td>Tos Crónica</td>
<td>Sangre en la Orina</td>
<td>Periodos Frecuentes/Doloroso</td>
<td>Sed No Usual</td>
</tr>
<tr>
<td>Tosiendo con Sangre</td>
<td>Problemas Sexuales</td>
<td>Sudores Nocturnos</td>
<td>Sueños Aterrorizadores</td>
</tr>
<tr>
<td>Latidos del Corazón Rápido/Irregulares</td>
<td>Dolor o Presión en el Pecho</td>
<td>Estrés Crónico en Trabajo/Familia</td>
<td>Fiebre</td>
</tr>
</tbody>
</table>
APPENDIX J. Primary Care Didactic Topics

1. Management of Essential Hypertension
2. Management of Diabetes
3. Thyroid disease
4. Dermatological Disorders (e.g. acne)
5. Gastrointestinal Disorders (e.g. IBS)
6. Respiratory Disorders (e.g. bronchitis)
7. Breast Disorders
8. Geriatric Visit
9. Behavioral Medicine (Depression, anxiety)
10. Immunization at specific ages and special circumstances
11. Pediatric/Adolescent issues
12. Annual Health Care Maintenance (includes DV, sexual assault & substance abuse)
13. Vaccinations
14. Headache
15. Osteoporosis
16. Lipid disorders
17. Obesity/ disorders of metabolism
APPENDIX K. Proposed WEBCIS OB/GYN Preventive Care

- **Breast Exam**
  - Annually

- **Cholesterol**
  - Starting at age 45, every 5 years

- **Colonoscopy**
  - Starting at age 50, every 10 years

- **Flu Vaccine**
  - 18-65 years, if at risk
  - 65 years, annually

- **Mammogram**
  - Starting at age 40, every 1-2 years then starting at age 50, every year

- **Pap Smear**
  - Every year, starting at age 21 or 3 years after sexual activity
  - Until age 65

- **Tetanus Diphtheria Vaccine**
  - Every 10 years

- **Pneumococcus**
  - Once at >65 years old

- **Chlamydia/Gonorrhea screening**
  - 18-25 years, annually or new sexual partner

- **Depression screening**
  - Starting at age 18, annually

- **ASA to prevent MI**
  - Starting at age 50 unless contraindicated

- **Tobacco use/Alcohol misuse**
  - Starting at age 18, annually

- **Osteoporosis screening**
  - Starting at 60-65 if at risk (wt less than 70 kg and no current HRT)
  - Starting 2 years after menopause & estrogen deprived
  - Starting at 65 years
References
