Patient Label:

Date:_________

PCOS Form: Follow-up Visit

Current Meds for PCOS:

Metformin Dose: ________________ since: ________

Spironalactone Dose: ________ or Propecia Dose:_________ since__________

TZD kind: ________ Dose: _________ since:__________

OCP: Type: ______________Dose: ________ Since: _________

Subjective Assessment: CC:

New Diarrhea: Y N Worse Fatigue: Y N Change in Weight: Y N (______); Change in diet: Y N(___________) Change in Exerc: Y N (_____________)

Menstruation: Spotting: Y N Discharge: Y N Regular: Y N: Pattern: _________

Using Progesterone w/d: Y N Trying to get pregnant: Y N; Method: _______________

Birth Control? Y N: Method: ______________

Hirsutism Changes: Y N

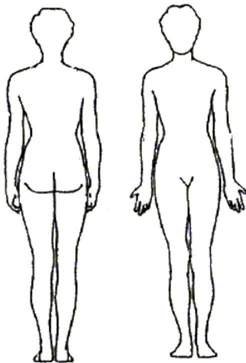
Menopause Sx: Y N

		P/S/F History from initial visit reviewed. **New Findings: ___None, or:** P: S: F: ROS:	Other sx?

Objective Assessment

1. Physical Exam *•Vital Signs—see flow sheet*

Skin: Striae: ______________, Acanthosis: _______________, Bruising: ___________________



Refer to Table:

SEVERITY (0-4+):	**Face**	**Chest**	**Adb/Back**	**Legs**
ACNE				
HIRSUTISM				

Thyroid:

Breast: NE or: Development: _______________, Mass: ___________, Discharge: ___________

Genital: NE or:

Labs

FSH:	LH:	TSH:	Testost: T: F:
DHEA-S:	Prolactin:	Glucose: F: 2 hpp:	Lipids: Total Trigl: HDL: LDL:
Androstenedione:	24hr free cortisol:	Other:	

Patient Label:

Date:__________

Medical Decision Making

Assessment

PCOS: Y N mild moderate severe
Dysmetal. syndrome: Y N ____
Hirsutism: Y N
Oligomenorrhea: Y N
Dyslipidemia: Y N
IGT or DM: Y N
Other:

CV Risk: Acute: Low Med High
Chronic: Low Med High
DM Risk: Acute: Low Med High
Chronic: Low Med High
Infertility Risk: Acute: Low Med High
Chronic: Low Med High

Plan:

Treatment Options:

Diet:
Exercise:
Meds: OCP: ___________ Metformin: __________ Aldactone/ Propecia: __________
Clomid:___________________ TZD: ________________ Statin: _________________
Other:

Follow-up Labs:

Chem 7	Lipids	Testost: T/F	ALT	Glu Tol.	hs CRP

Counseling/Coordination of Care Time: ______________________ Total time with pt.: ___________

Pathophysiology:

Weight Management:

Exercise: __d/wk.; __min; Type____________; Precautions Stop if any SOB/ CP. If at high CV risk, talk to PCP about having ECG vs.stress test before starting exercise program. If DM, check glucose and follow appropriate guidelines. Diet: ↓fat content___; calorie/d____; carb budgeting________; portion control________

Behavior Mod. Techniques: Biofeedback ______; hypnosis_____; relaxation tech. ___
Stress mngmt. _____; Recomm. Reading______________
Brochures:____________; Meds: ______________________
Barriatric Surg Ref: ________________________________

Materials/ Information given:

Instruction sheet
PCOS information
Fast food
Portion Control
Food Diary information
Hypnosis information
Diabetes medication information
Walking program
_____Kcal/ day diet
Hirsutism Information

Patient Label:

Date:__________

Bariatric Surgery Information

Materials given to patient, cont.

Statin information, heart disease information

Notes/Comments/Pressing Concerns:

Flowsheet reviewed and updated

Labs to be reviewed by phone

Labs reviewed and pt. Notified

Return Visits:

Physician: ______________________________

Referrals:

Physician: ________________________________

RD : _________________________________

Other : ________________________________

Signature: ____

CC: ____

Patient Instructions: