

**WOMEN'S ANNUAL EXAM: CONFIDENTIAL MEDICAL REVIEW AND UPDATE**

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

Reason for today's appointment: \_\_\_\_\_

\* **FEMALE HISTORY:** First day last menstrual period \_\_\_\_\_ Circle One Date of last PAP: \_\_\_\_\_

Have you had a hysterectomy? ..... N Y Cause: \_\_\_\_\_ Ovaries left? Y N
Do you have any past history of abnormal PAPS? ..... N Y When: \_\_\_\_\_
Did your mother take DES hormone while pregnant with you? ..... N Y Don't know
Any unusual vaginal (circle): discharge, itching, odor or burning? ..... N Y
Does your male partner have pain or discharge from his penis? ..... N Y
Any history of pelvic or sexually transmitted diseases (circle): HIV,
herpes, genital warts, gonorrhea, Chlamydia, trichomonas? ..... N Y
Should we confidentially check for pelvic infection or for HIV? ..... N Y
Have you had a new partner in the last three months? ..... N Y Total # of partners in the last 3 years: \_\_\_\_\_
Any (circle): pelvic pain, pain with sex or urination? ..... N Y How long with current partner? \_\_\_\_\_
Problems with recurrent vaginal yeast or urinary infections? ..... N Y
Any menstrual problems (circle): very heavy flow or cramps, spotting
between periods or after sex, irregularity, bad PMS? ..... N Y
Number of days of flow \_\_\_\_\_ Number days of cycle \_\_\_\_\_
Do you think or know you've reached menopause (circle): leaky urine, hot
flashes, night sweats, vaginal dryness, severe sleep or mood problems? .. N Y On Hormones?: Y N
Have you given birth to any babies over 9 lbs. in size? ..... N Y Approx. age of mother's menopause: \_\_\_\_\_
How many times have you been pregnant? \_\_\_\_ How many deliveries? \_\_\_\_\_

\* **BREAST CANCER ASSESSMENT:** Date of last breast exam \_\_\_\_\_ Last Mammogram:
Any (circle): breast lumps, biopsies, cancer or abnormal mammograms? ..... N Y
Any (circle): nipple discharge, breast or nipple pain? ..... N Y
Do you have any family history of (circle): breast or ovarian cancer? ..... N Y Who?
Total # of months spent pregnant \_\_\_\_\_ spent breast feeding \_\_\_\_\_
Currently breast feeding? ..... N Y How long (total)?

\* **OSTEOPOROSIS RISK ASSESSMENT:**

Do you have any of the following? (Please circle any/all that apply) N Y

Caucasian; smoker; slender or lightweight frame; any loss of height; early or
surgical menopause; prolonged breastfeeding; family history of loss of height,
of osteoporosis, or of hip or spine fractures; not much weight-bearing exercise;
more than 2 oz. alcohol/day; more than 2 cups coffee/day; less than 2
servings/day of dairy products; history of restrictive dieting; history of
prolonged bedrest, blood thinning, thyroid, ant seizure or steroid medications;
large doses of vit. A or vit. D.

\* **FAMILY PLANNING & SEXUAL HISTORY:** Sexual Partners are: M F Both. Birth Control Method \_\_\_\_\_

Do you sometimes have sex without protection? ..... N Y
Could you possibly be pregnant or should w just check? ..... N Y
Would you like to change or improve your birth control method? ..... N Y
Are you currently trying to get pregnant or planning to try? ..... N Y Taking Folic acid? N Y
Any questions or concerns regarding sex or birth control? ..... N Y Know Rubella status? N Y

**PLEASE TURN OVER**

\* **GENERAL MEDICAL HISTORY AND REVIEW**

Any other major health concerns today? ..... N Y
Any problems with eating or with stomach or bowels? ..... N Y

Any problems with heart, chest pain, palpitations? ..... N Y  
 Any eye, ear, nose, throat, skin or nerve problems? ..... N Y  
 Any new, changed, dark, large, bleeding or irregular moles? ..... N Y  
 Any other updates on medical history (pregnancy, illness, surgery)? ..... N Y  
 Any updates on your family medical history? ..... N Y  
 Any problems with recurrent, distressing, intrusive, irrational or unreasonable  
 Thoughts or behaviors? ..... N Y  
 Any major current social stresses (circle): Marriage, Divorce, Separation, ..... N Y  
 Job, Deaths, Housing, Family, Relationships, Illness? ..... N Y  
 Any sexual or physical abuse ... now or in the past? ..... N Y Have you had counseling to help with this? Y N

**\* REVIEW ALL MEDICATIONS YOU ARE TAKING:** (Include occasional & over-the-counter medications, as well as vits.& herbs)

Medication	Dosage	Take how often?	What for

**\* REVIEW ALL DRUG ALLERGIES:** Medication \_\_\_\_\_ What happened when you took it? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**\* HEALTH HABITS REVIEW & PREVENTION UPDATE**

Formal Exercise (# hours/wk): \_\_\_\_\_  
 Are you regularly exposed to cigarette smoke - for example, do you live or  
 Work closely with a smoker? Y N For how many years? \_\_\_\_\_  
 Have you ever been a smoker? Y N For how many years? \_\_\_\_\_  
 # pks/d smoked, (on average) \_\_\_\_\_ Years Quit \_\_\_\_\_  
 Currently smoking cigarettes? Y N # of pks/d \_\_\_\_\_  
 Caffeine ( # drinks / d ): \_\_\_\_\_  
 Alcohol ( # drinks / wk): \_\_\_\_\_ Ever had an alcohol problem? N Y  
 Street drugs (type & amount): \_\_\_\_\_  
 Seatbelt Worn: Always / Occasional / Never  
 Self Breast Exam: Monthly / Occasional / Never  
 Bike Helmet Worn Always / Occasional / Never / NA  
 Last Cholesterol level: \_\_\_\_\_ Date: \_\_\_\_\_ Never Done  
 Last Tetanus shot: \_\_\_\_\_  
 Multivitamins? \_\_\_\_\_ Calcium? \_\_\_\_\_ Iron? \_\_\_\_\_ Folic Acid? \_\_\_\_\_  
 Last Colon cancer screen by hem cult cards: \_\_\_\_\_  
 By Flexible Sigmoidoscopy or by Colonoscopy \_\_\_\_\_  
 Last Chest X-Ray \_\_\_\_\_ Last EKG \_\_\_\_\_  
 Last TB Skin test: \_\_\_\_\_  
 Last Pneumonia shot: \_\_\_\_\_  
 Ever had German Measles shot or illness? \_\_\_\_\_ N \_\_\_\_\_ Y \_\_\_\_\_ Not sure.