Southwest Family Physicians
YOUR FAMILY IS OUR FAMILY

Woman's Annual Exam

Confidential Medical Review and Update

Name: _____ Age: _____ Date: _____

Reason for today's appointment: _____

FEMALE HISTORY

First day of last menstrual period: _____ Date of last PAP Smear: _____

Have you had a hysterectomy? .....N Y

Cause for hysterectomy? _____

Do you have ovaries left?.....N Y

Past history of abnormal PAP Smears?.....N Y

When?_____

Did your mother take DES hormone while pregnant with you?.....N Y

Any usual vaginal (circle): discharge, itching, odor, burning?.....N Y

Does your male partner have pain or discharge from his penis?.....N Y

Any history of Sexually Transmitting Diseases (STD)?.....N Y

(Circle): HIV, herpes, genital warts, gonorrhea, chlamydia, trichomonas

Would you liked to be checked confidentially for HIV or any other STD?.....N Y

Have you had a new sexual partner in the past three months?.....N Y

Total number of partners in the past five years? _____

Any (circle): pelvic pain, pain with sex or urination?.....N Y

How long have you been with your current partner? _____

Any menstrual problems (circle): heavy flow, cramps, spotting between periods or after sex, irregularity, bad PMS?.....N Y

Number of days of your flow: _____ Number of days of your cycle: _____

Do you think you've reached menopause?.....N Y

Any (circle): leaky urine, hot flashes, night sweats, vaginal dryness, sleep or mood problems?.....N Y

Are you on hormones?.....N Y

Approx. age your mother went through menopause? _____

Have you given birth to any babies over 9 lbs. in size?.....N Y

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

OSTEOPOROSIS RISK ASSESSMENT

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

Caucasian, smoker, slender or lightweight frame; any loss of height, early or surgical menopause, prolonged breast feeding; 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 bed rest, blood thinning, thyroid, and seizure or steroid medications, large doses of Vitamin A or Vitamin D.

FAMILY PLANNING & SEXUAL HISTORY

Sexual partners are (circle): M F Both

Birth control method: _____

Do you sometimes have sex without protection?.....N Y

Could you possible be pregnant or should we 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

Do you have any questions or concerns regarding sex or birth control?.....N Y

Do you know your Rubella status?.....N Y

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Woman's Annual Exam (back page)

GENERAL MEDICAL HISTORY AND REVIEW

Do you have any major health concerns today?.....N Y
If yes, describe: _____
Any major illness, injury, surgery, or hospitalization since your last visit.....N Y
Any problems with eating or your stomach or bowels?.....N Y
Any problems with check pain, palpitations or heart?.....N Y
Any problems with shortness of breath or cough?.....N Y
Any new, changed, dark, large, itching, bleeding, or irregular moles?.....N Y
Any problems with eyes, ear, nose, throat, skin, or nerve problems?.....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, financial, legal, work, deaths, housing, family, relationships, illness?.....N Y
Any updates on your Family Medical History?.....N Y
If yes, describe: _____
Any sexual or physical abuse?.....N Y
If yes, describe: _____
Have you had counseling to help with it? _____

DRUG ALLERGIES (Medication and reaction)**:**

_____

CURRENT MEDICATIONS (Include occasional and over the counter medications, vitamins, aspirin, laxatives, and supplements)

Medication	Dosage	Taken how often?	Taken for what reason?

HEALTH HABITS REVIEW AND PREVENTION UPDATE

Formal exercise (# hours/week): _____
Have you ever been a smoker?
How many years? ____ How many cigarettes per day (on average): ____
Do you currently smoke cigarettes or use any other tobacco products?.....N Y
How many per day (on average)? _____ Do you live or work with a smoker?.....N Y
Do you drink alcohol?.....N Y
Average number of drinks per day _____ Do you think you need to cut back on your drinking?.....N Y
Do you drink coffee, tea, sodas, or other caffeinated drinks?.....N Y
Average drinks/cups per day_____
Are you using street, recreational, or illegal drugs?.....N Y
Type/amount: _____
Would you like to get an annual flu shot?.....N Y
Seatbelt worn: Always / Occasional / Never Bike helmet worn: Always / Occasional / Never
Approximate **date** of last:
Chest X-Ray_____ EKG (electrocardiogram)_____ Complete eye exam_____ Pneumonia shot _____
Colon cancer screening: hemoccult cards _____ or colonoscopy/flexible sigmoidoscopy _____
Tetanus shot _____ Cholesterol level _____
Ever had German measles shot or illness?.....N Y