Southwest Family Physicians
YOUR FAMILY IS OUR FAMILY

Women's Annual Exam

Legal Name: ____ Age: _________ Date: _____________
Preferred name: _________________________ Pronoun: ____________

FEMALE HISTORY

First day of last menstrual period: ____________________

How many days between periods? _____ How many days is your flow? _____

How many times have you been pregnant? _______ How many deliveries? _________

Date of last Pap smear: _____________________

Any history of abnormal Pap smears?	☐ Yes	☐ No
Have you had a hysterectomy? If yes, reason? ____________________________	☐ Yes	☐ No
Any menstrual problems like heavy flow, cramps, spotting between periods or after sex, irregularity, bad PMS? (circle symptoms)	☐ Yes	☐ No
Any unusual vaginal discharge, itching, odor, or burning? (circle symptoms)	☐ Yes	☐ No
Any pelvic pain, pain with sex, or pain with urination?	☐ Yes	☐ No
Any problems with urinary incontinence (losing your urine when you don't mean to?)	☐ Yes	☐ No
Have you reached menopause?	☐ Yes	☐ No
Any problems with hot flashes, night sweats, vaginal dryness, sleep disturbance or mood problems?	☐ Yes	☐ No

Date of last mammogram: _________________________

Do you have any family history of breast or ovarian cancer?	☐ Yes	☐ No
Do you have any breast or nipple pain or nipple discharge?	☐ Yes	☐ No
Do you have any history of breast lumps, biopsies, or abnormal mammograms?	☐ Yes	☐ No
Currently breastfeeding?	☐ Yes	☐ No

FAMILY PLANNING & SEXUAL HISTORY

Sexual partners are (circle): M F Both

Birth control method: ______________________________

Are you currently sexually active?	☐ Yes	☐ No
Have you had more than one partner in the last year?	☐ Yes	☐ No
Would you like to change or improve your birth control method?	☐ Yes	☐ No
Do you have any worries or concerns about sexual function?	☐ Yes	☐ No
Any history of sexually transmitted infections (STIs)? (Circle): HIV, herpes, genital warts, gonorrhea, chlamydia, trichomonas	☐ Yes	☐ No
Would you like to be confidentially checked for HIV or any other STI?	☐ Yes	☐ No
Are you currently trying to get pregnant or planning to try soon?	☐ Yes	☐ No

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HEALTH HABITS REVIEW

Formal exercise (# hrs/ week) ____________________

What are your forms of exercise? ____

What is your stress reduction practice? ____

How many hours a night do you sleep? __________ Any sleep issues?	■ Yes	■ No
Do you follow any special diet (vegan, vegetarian, etc?) What kind? _________________	■ Yes	■ No
Do you drink coffee, tea, sodas, or other caffeinated drinks?	■ Yes	■ No
Are you currently smoking?	■ Yes	■ No
Have you ever been a smoker?	■ Yes	■ No

If yes, how many years? ________ How many cigarettes/day (on average)? _________

GENERAL REVIEW OF SYMPTOMS

Any major illness, injury, surgery, or hospitalization since your last visit?	■ Yes	■ No
Any problems with eating or your stomach or bowels?	■ Yes	■ No
Any problems with chest pain or palpitations?	■ Yes	■ No
Any problems with shortness of breath or cough?	■ Yes	■ No
Any problems with eyes, ears, nose, or throat?	■ Yes	■ No
Any new, changed, dark, large, itching, bleeding, or irregular moles? Any rashes?	■ Yes	■ No
Any problems with numbness, tingling, or other nerve problems?	■ Yes	■ No
Any headaches, neck pain, back pain, or joint pain?	■ Yes	■ No
Any problems with recurrent, distressing, intrusive, irrational, or unreasonable thoughts or behaviors?	■ Yes	■ No
Any updates on your family history? Discuss these with your medical assistant, if so.	■ Yes	■ No

OSTEOPOROSIS RISK ASSESSMENT

Have you had your bone density checked with a DEXA scan? If so, what year? _______	■ Yes	■ No
Do you have a history of a fracture in your adult life that occurred without significant trauma?	■ Yes	■ No
Do you have a parent who has had a hip fracture?	■ Yes	■ No
Do you drink more than 3 drinks of alcohol a day?	■ Yes	■ No
Have you ever used steroid medications (ie prednisone) for more than 3 months continuously?	■ Yes	■ No
Do you have any of the following conditions (circle): rheumatoid arthritis, type 1 diabetes, hyperthyroidism, premature menopause (< 45 years old), malabsorption, history of weight loss surgery, chronic liver disease, or osteogenesis imperfecta?	■ Yes	■ No