ANNUAL GYNECOLOGICAL/ WELL WOMAN VISIT

Name _____ Age _____ Date _____

Primary Care Physician_____ **ALLERGIES:**_____

CC Any problems to discuss with the doctor? _____

List prescriptions that need to be refilled: _____

HPI: First day of last menstrual period **OR** year of menopause _____
Menstrual cycle: Periods occur every _____days, lasting _____ days long, flow is: Light/Moderate/Heavy ____pad/day
Cramps: None Mild Moderate Severe
Are you having any menstrual problems? **NO YES**, describe _____
If you are menopausal, are you having any uterine bleeding? **NO YES**_____
Are you having any: bleeding between periods? **NO YES**_____
pelvic pain? **NO YES**_____
irritating vaginal discharge? **NO YES**_____
vulvar itching or rashes? **NO YES**_____
Are you currently sexually active? **NO YES** If so, what method of contraception do you use?_____
Are you having any pain or bleeding with intercourse? **NO YES**_____
Do you perform self-breast exams? **NO YES** Are you having breast pain**? NO YES**_____
Have you noticed a new breast lump? **NO YES**_____

PMH: Since your <u>last annual exam,</u> have you had:

Any surgeries or medical procedures? **NO YES** What?_____ DATE _____
Any hospitalizations? **NO YES** What?_____ DATE _____
New illnesses or medical diagnoses? **NO YES** What?_____ DATE _____
Pregnancies? Injuries? **NO YES** What?_____ DATE _____

Please list your current medications (including non-prescription), vitamins, and herbs:_____

_____

FH: Any change in your family's medical history since <u>last annual exam</u>? **NO YES** What?_____

SOCHX:
Do you smoke? **NO YES** How much? _____
Do you drink alcohol? **NO YES** How much? _____drinks per day / week / month (circle one)
Do you drink caffeine? **NO YES** How much? _____cups or glasses per day / week (circle one)
Do you use any street drugs? **NO YES** How much? _____
Do you get calcium in your diet? **NO YES**
Or in a supplement? **NO YES**
Do you exercise? **NO YES** How much? _____
What is your occupation? _____

Are you presently: Married Living with significant other Widowed Single Divorced

Who lives at home: _____Pets: Dog / Cat / Fish / Other _____

Health Review: Are you currently having problems with: ____ NO COMPLAINTS

____ breathing/lungs _____ heart ____ stomach ____ bowels

____ urination/incontinence _____ skin ____ eyes, ear, nose, or throat ____ fever

____weight loss or gain _____ joints/muscles ____ thyroid gland ____ lymph nodes

____depression/anxiety _____ physical /verbal/ or sexual abuse ____ OTHER_____

_____