WOMEN'S MEDICAL SPECIALTY ANNUAL EXAM

Patient's Name: _____ Age: _____ Birth Date: ___/___/___ Today's Date : ___/___/___
Primary Care Physician: _____

Menstrual History

First day of last menstrual period: ___/___/___ Age at first period_____ Are your periods regular? ☐ Yes ☐No
Days between periods (start to start) _____ Days your period last? _____ Are they heavier then in the past? ☐ Yes ☐No
Hysterectomy ☐ Yes ☐ No If periods stopped, at what age _____ Are you currently sexually active? ☐ Yes ☐No
Current birth control ☐ None ☐ Birth Control Pills ☐Tubal ligation ☐IUD ☐Condoms
☐DepoProvera ☐ Nuvaring ☐ Vasectomy ☐Patch ☐Implanon ☐
Comments: _____
_____
_____

Past Medical & Family History

	Self	**Fam**		**Self**	**Fam**		***Self***	***Fam***
Cancer	☐	☐	Heart disease	☐	☐	Thyroid Disease	☐	☐
Osteoporosis	☐	☐	High Blood Pressure	☐	☐	Other (please specify)_____		
Diabetes	☐	☐	High Cholesterol	☐	☐	_____		
Asthma	☐	☐						

Surgeries or Hospitalizations **since last visit** ☐ **NONE**
Type of Surgery or Reason for Hospitalization (Please include dates)
1. _____
2. _____
3. _____
List any drug/food allergies: ☐ **NONE** If yes, please specify _____

Medications-Please list ***all*** current medications (including prescriptions, hormone replacement, vitamins, calcium & over the counter medications) ☐ **NONE**
Medication
1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Social History

	Yes	No	
Exercise regularly?	☐	☐	If so, how often _____
Smoke cigarettes?	☐	☐	If so, how many packs per day _____
Drink alcohol regularly?	☐	☐	If so, how many drinks per week _____
Are you under stress that you can't manage?	☐	☐	
Do you have any questions about domestic/sexual abuse?	☐	☐	