ALL CARE FOR WOMEN, LLP
YEARLY EXAMINATION

NAME____ AGE________ DATE________________________

OFFICE USE ONLY			
BP______________	WEIGHT______________	HEIGHT________________	URINE DIP________________
LAST YEARLY VISIT______________	LAST PAP / HPV________________	LAST MAMMOGRAM______________	
LAST DEXA____________________	LAST COLONOSCOPY__________________	FLU SHOT________________	

Allergies____

Current medications, vitamins, herbs____

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What do you use to prevent pregnancy? ____

Are you planning a pregnancy within the next year? YES / NO

Last menstrual period________________________________ Age of Menopause ____________________

How often do you get a period? _______________________ How many days is your flow? ______________

Do you feel your periods impact the quality of your life? YES / NO

Do you experience irregular or inconsistent bleeding? YES / NO

Are you experiencing any **NEW** urinary symptoms such as: Urgency, Frequency, Pain? YES/NO

Are you experiencing any **NEW** leaking of urine with: Coughing, Sneezing, Running, Exercising? YES/NO

Do you want testing for the STDs: Gonorrhea, Chlamydia, Trichomonas YES / NO

Do you want additional **laboratory** STD tests for: Syphilis, Herpes, Hepatitis, HIV YES / NO

ANY CHANGES IN YOUR HEALTH - since last visit?

Including hospital stays, injuries, surgeries, stress/emotional related illness. Please explain:

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UPDATED FAMILY HISTORY -- since last visit - Including death, illness, and divorce:

____

____

SOCIAL HISTORY Please circle: Single Married Divorced Widowed Separated Life Partner

How long have you been with current partner? _______________________________________

Do you do self-breast exam? Y / N How often? ______________________________________

Tobacco use? Y / N How many packs per day ____________ X __________yrs.

Alcohol consumption? Y / N Explain: ____

Recreational drugs? Y / N Explain: ____

Calcium intake ____

Exercise routine ____

Caffeine consumption? Y / N Explain: ____

ANY PROBLEMS OR CONCERNS

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