Orange Blossom Women's Group
Annual Exam Form

Name_____ Date_____

Please check, circle, or fill in for ALL answers (you may mark more than one choice). Please mark 'none' if the choice does not pertain to you.

Date of last Pap Smear _____
History of abnormal pap smear ☐ Yes ☐ No If yes, when_____
If yes, how were you treated? ☐LEEP ☐Cryotherapy ☐Resolved

Menstrual Cycle
Last menstrual period_____ Do you have normal periods ☐ Yes ☐ No
If abnormal, please describe: _____
Menstrual flow ☐ heavy flow ☐moderate flow ☐light flow

Vaginal signs/symptoms:
☐Abnormal discharge. If so, what color _____
☐Vaginal pain or burning ☐Vaginal itching
How long has this been going on for_____

Sexual activity
☐Yes ☐No ☐ monogamous relationship ☐New partner

Contraception
☐ Currently on oral contraception. If so, what type _____
☐ Interested in starting contraception
☐ Actively trying to conceive

Current mode of contraception
☐ Oral pills ☐ Condoms ☐ Tubal ligation ☐Partner vasectomy ☐ IUD – what brand _____

Menopause
☐ On Hormone replacement therapy. If so what type _____
☐ Hot flashes ☐ Night sweats ☐ Irregular bleeding ☐ Mood swings ☐ Anxiety ☐ Insomnia

Do you need and refills on any medications? _____
Date of last mammogram_____ Results _____
Date of last Dexa bone scan _____ Results _____

Review of Symptoms (please check all that apply)

Constitutional:
☐Body aches ☐Fevers ☐Chills ☐fatigue ☐loss of appetite
☐Weight loss ☐Weight gain

Dermatology

☐Skin change ☐Hair loss ☐Hair growth ☐Acne ☐Easy bruising

Ears/Nose Throat

☐ Drainage ☐Itching ☐pain ☐redness

Respiratory

☐ Cough ☐Chest pain with breathing ☐Shortness of breath

Cardiac

☐Chest pain ☐Elevated BP ☐Irregular heart beat

Gastrointestinal

☐Abdominal pain ☐Appetite change ☐Bloating ☐Blood in stool

☐ Changes in bowel movements

Genito-urinary

☐Difficulty urinating ☐Pain with urination ☐Flank pain

☐Frequent UTI ☐Irregular menses

Musculoskeletal

☐Back pain ☐ Joint pain ☐Muscle pain

Neurological

☐Confusion ☐Dizziness ☐Headache ☐ Loss of consciousness ☐ Memory changes

Psychological

☐Anxiety ☐Depression ☐Insomnia ☐Irritability

Hematology/Lymph

☐Bleeding ☐Bruising ☐Enlarged lymph nodes ☐Fever ☐fatigue

Endocrinology

☐ Hair growth ☐Hot flashes ☐Temperature intolerance ☐Sexual dysfunction

Family History

Have you or a close relative (father, mother, brother, sister, uncle, aunt, grandfather or grandmother) had any of the following:

☐ 1 breast cancer diagnosed under the age of 50
☐ Ovarian cancer diagnosed at any age
☐ 3 breast cancers on the same side of the family diagnosed at any age
☐ 1 colon cancer and/or uterine cancer diagnosed under the age of 50
☐ 3 or more colon and/or uterine cancers on the same side of the family at any age