Women's Healthcare Physicians
Established Patient Yearly Exam Update

Name: _____ **Date of Birth** _____/_____/_____
Today's Date: _____/_____/_____

Any Concerns to Discuss Today? _____
_____

List All Medications: _____
_____

Drug Allergies: _____

Date of Last Pap _____ **Date of Last Colonoscopy** _____
Date of Last Mammogram _____ **Primary Care Provider** _____
Date of Last Bone Density _____

Menstrual History (skip this section if postmenopausal):
Last menstrual period: _____ How often do you have a period? _____
Duration of bleeding? _____ Spotting between periods? Yes _____ No _____
Amount of flow? Light _____ Moderate _____ Heavy _____
Pain with menses? None _____ Mild _____ Moderate _____ Severe _____

Contraception (skip this section if postmenopausal):
None / Birth Control Pill / Tubal / IUD / Vasectomy / Rhythm / Condom / Patch / Ring
Do you use it regularly? Yes _____ No _____ Do you plan to get pregnant this year? Yes ___ No ___
Do you want information about birth control? Yes ___ No ___
Are you and your partner satisfied with the current method? Yes _____ No _____ If not, please explain: _____

Sexual History: Satisfactory _____ Unsatisfactory _____ Not Sexually Active _____
Please specify: Single /Married/ Divorced/ Widowed/ Live with Partner
Has there been any recent change in your relationship? Yes _____ No _____ if yes, please specify: _____
Have you had a new partner within the last 12 months? Yes _____ No _____

Pregnancies:
Total number of pregnancies _____ Preterm Births _____ Miscarriages _____ Ectopic (tubal) _____
Abortions _____ Living Children _____

Family History: Has anyone in your immediate family had any of the following?
Breast Cancer Yes _____ No _____ Heart Attack age 60 or less Yes _____ No _____
Ovarian Cancer Yes _____ No _____ High Cholesterol Yes _____No _____
Colon Cancer Yes _____ No _____ Thyroid Disease Yes _____ No _____
Blood Clot in the Leg or Lung Yes _____ No _____

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Name: _____ **Date of Birth**: _____/ _____/ _____

Since Your Last Visit, have you had any changes in your medical history? _____
_____
_____
_____

Review of Systems: Are you currently experiencing any of the following?

Weight Loss	Yes	No	Muscle Weakness	Yes	No
Weight Gain	Yes	No	Depression	Yes	No
Fatigue	Yes	No	Anxiety	Yes	No
Vision Changes	Yes	No	Skin Changes	Yes	No
Sinus Problems	Yes	No	Hot Flashes	Yes	No
Mouth Sores	Yes	No	Easy Bruising	Yes	No
Swelling of Legs	Yes	No	Enlarged Lymph Nodes	Yes	No
Chest Pain	Yes	No	Joint Pain	Yes	No
Cough	Yes	No	Change in Bowel Habits	Yes	No
Shortness of Breath	Yes	No	Nausea/Vomiting	Yes	No
Headaches/Migraines	Yes	No	Urinary Incontinence	Yes	No
Numbness	Yes	No	Urgency/Frequency	Yes	No

Well Being:

Do you take calcium supplements?	Yes____ No ____
Do you exercise regularly?	Yes____ No ____
Are you currently dieting?	Yes ____ No ____
Do you wear your seatbelt?	Yes ____ No ____
Do you use street drugs?	Yes ____ No ____

Tobacco Use _____ Packs/day
Alcohol Use _____ Drinks/week

Have you been vaccinated with Gardasil (HPV vaccine)	Yes ____ No ____
Have you had a Hepatitis A/B vaccine?	Yes ____ No ____

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