Capital Womens Care **ANNUAL EXAM REVIEW**

NAME _____ DATE _____ AGE _____ EMAIL _____

Birth Control: method currently used _____ How long? _____

Periods:	**Breast (currently):**
• Date of last menstrual period ____ /____ /_____ • How often do you get your period?_____ • Periods last _____number of days • Periods are **painful** **No ( ) Yes ( )** • Any medications used: _____ • Do the medications relieve your pain ? _____ • Excessively **heavy** **No ( ) Yes ( )** • Heavy Days (# tampons or pads) _____	side • Discharge No ( ) Yes ( ) _____ • Lump/s No ( ) Yes ( ) _____ • Pain No ( ) Yes ( ) _____ • Self Exam No ( ) Yes ( )

FOR WOMEN WHO ARE MENOPAUSAL

Age at menopause _____	Hot Flashes No ( ) Yes ( ) Insomnia No ( ) Yes ( ) Night Sweats No ( ) Yes ( ) Vaginal Dryness No ( ) Yes ( )	Do you take Calcium supplements No ( ) Yes ( )
Hormone Replacement Therapy No ( ) Yes ( )	HRT medications:	Years taken:

ADDITIONAL SYMPTOMS

Abnormal bleeding	No ( ) Yes ( )	Waking to urinate	No ( ) Yes ( )
Anxiety	No ( ) Yes ( )	Sexual dysfunction	No ( ) Yes ( )
Decreased desire for sex	No ( ) Yes ( )	Sleep disturbances	No ( ) Yes ( )
Depression	No ( ) Yes ( )	Urinary Incontinence	No ( ) Yes ( )
Difficulty falling asleep	No ( ) Yes ( )	Urinary urgency	No ( ) Yes ( )
Painful intercourse	No ( ) Yes ( )	Vaginal discharge	No ( ) Yes ( )
History of Infertility	No ( ) Yes ( )	Vaginal itching	No ( ) Yes ( )

MEDICATIONS REVIEW (be sure to include over the counter meds and supplements)

NAME (BRAND OR GENERIC)	DOSAGE	HOW OFTEN	START DATE	NAME OF PRESCRIBING PHYSICIAN

SINCE YOUR LAST ANNUAL EXAM:

Have you had any **surgery**? No ( ) Yes ( )	Type:
Had any new **medical problems**? No ( ) Yes ( )	Type:
Developed any new **allergies**? No ( ) Yes ( )	Type:
Are there recent **family members illnesses** we should know about? No ( ) Yes ( )	Explain:
Have you had any major **life changes** this year (Health, Pregnancy, Family or Social Explain:	No ( ) Yes ( )
Additional concerns?	No ( ) Yes ( )

Please continue ….TURN over. . .

NUTRITION: Calcium supplement No ( ) Yes ( ) Vitamin D No ( ) Yes ( )

SOCIAL HISTORY ( ) MARRIED ( ) SINGLE ( ) WIDOW ( ) DIVORCED

- Are you currently sexually active ? No ( ) Yes ( ) With a: Man ( ) Woman ( ) Both ( )
- How many sexual partners do you currently have? _____ during your lifetime? _____

EXERCISE: TYPE _____ **FREQUENCY** _____

TOBACCO USE: CURRENT: No ( ) Yes ( ) FORMER: No ( ) Yes ( ) NEVER ( )

TYPE_____ PACKS / DAY _____ YEARS SMOKED _____ Passive Smoke Exposure _____

ALCOHOL USE: CURRENT: No ( ) Yes ( ) FORMER: No ( ) Yes ( ) NEVER ( )

AVERAGE DRINKS/WEEK _____ TYPE _____ AMOUNT _____

YEARS QUIT _____ LAST DRINK _____

CAFFEINE USE: CURRENT: No ( ) Yes ( ) TYPE _____ AMT DAILY_____

HISTORY OF DOMESTIC VIOLENCE (CONFIDENTIAL):

ARE YOU A VICTIM OR SURVIVOR OF PHYSICAL OR SEXUAL ABUSE No ( ) Yes ( )

WHEN WAS YOUR LAST ?

TEST	DATE	NORMAL	ABNORMAL	
LAST PAP TEST				---
MAMMOGRAM				
OSTEOPOROSIS TEST (DEXA OR BONE DENSITY SCAN)				
COLONOSCOPY To be repeated in _____ yrs				

Do you want Sexually Transmitted Diseases testing (STDs) ?	**No ( ) Yes ( )**
I request testing for: (please check) _____ Gonorrhea _____ Chlamydia	*Chlamydia and Gonorrhea* are two of the most commonly transmitted STDs in the US. • *Symptoms* can include: Discharge, irregular bleeding, abnormal or pelvic pain, painful intercourse, vague bladder symptoms or they may be "silent" with no symptoms at all. • *Testing:* a sample is taken from the cervix, similar to a PAP smear. • *Cost:* ranges fro $75- $125, depending on the lab your insurance requires us to use, and **MAY or MAY NOT** be covered by the insurance
I request testing for: (please check) ____ Syphillis ____ Hepatitis B /C ____ HIV	• *Syphyllis, Hepatitis B / C and HIV (Aids Virus)* can be tested with a blood sample. • Your insurance **MAY or MAY NOT** cover the test.
Please sign here to authorize this testing:	***DATE:***

GARDISIL VACCINE

If you are age 26 or LESS, have you received the Gardisil Vaccine for Human Papilloma Virus (HPV) To help prevent genital warts and cervical cancer? No ( ) Yes ( )
If you have not received the vaccine, are you interested in getting the vaccine at this time? No ( ) Yes ( )

Thank you **for taking the time to share this information so we can be your partner in your health care.**

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