

NAME _____ DATE _____ AGE _____ EMAIL _____

Birth Control: method currently used _____ How long? _____	
Periods: <ul style="list-style-type: none"> • 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) _____ 	Breast (currently): <div style="text-align: right; margin-bottom: 5px;">side</div> <ul style="list-style-type: none"> • 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 () Do you take Vitamin D3 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 () Had any new medical problems ? No () Yes () Developed any new allergies ? No () Yes () Are there recent family members illnesses we should know about? No () Yes ()	Type: Type: Type: Explain:
Have you had any major life changes this year (Health, Pregnancy, Family or Social) Explain:	No () Yes ()
Additional concerns?	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	<u>Chlamydia and Gonorrhea</u> are two of the most commonly transmitted STDs in the US. <ul style="list-style-type: none"> • <u>Symptoms</u> can include: Discharge, irregular bleeding, abnormal or pelvic pain, painful intercourse, vague bladder symptoms or they may be "silent" with no symptoms at all. • <u>Testing:</u> a sample is taken from the cervix, similar to a PAP smear. • <u>Cost:</u> 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	<ul style="list-style-type: none"> • <u>Syphillis, Hepatitis B / C and HIV (Aids Virus)</u> 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 <u>Gardasil Vaccine for Human Papilloma Virus (HPV)</u> 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.