Annual Exam Review

NAME:	DOB:	DATE:
_____	_____	_____
PREFERRED NICKNAME:	**EMAIL:**	**PRIMARY CARE PROVIDER:**
_____	_____	_____

CURRENT BIRTH CONTROL METHOD: _____ **How long?** _____

Periods:	**Breast (currently):**
Date of last menstrual period _____	Left or Right Breast (please circle one)
How often do you get your period (Every how many days)? _____	Discharge No ( ) Yes ( )
Periods last _____ number of days; painful? No ( ) Yes ( )	Lump(s) No ( ) Yes ( )
Any medications used? _____	Pain No ( ) Yes ( )
Do the medications relieve your pain? No ( ) Yes ( )	Self- Exam No ( ) Yes ( )
Excessively heavy? No ( ) Yes ( )	
Heavy days (# tampons or pads) _____	

FOR WOMEN WHO ARE MENOPAUSAL

Age at menopause: _____	Hot Flashes No ( ) Yes ( )	Night Sweats	No ( ) Yes ( )
Hormone Replacement Therapy? No ( ) Yes ( )	Insomnia No ( ) Yes ( )	Vaginal Dryness	No ( ) Yes ( )
HRT medications: _____			

ADDITIONAL SYMPTOMS

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

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

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

PHARMACY

Name:	Address:

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 any recent family members illnesses we should know about?	No ( )	Yes ( )	If yes, please describe:
Have you had any major life changes this year? (Health, Pregnancy, Family, or Social)	No ( )	Yes ( )	Please Explain:
Additional concerns:			

Would you like to be screened for sexually transmitted diseases (STDs)? No ( ) Yes ( )

Chlamydia and Gonorrhea are two of the most common transmitted bacterial STD's in the United States. These infections may present discharge, irregular bleeding, abdominal or pelvic pain, painful intercourse or they may be silent with no symptoms at all. If you request testing, a sample is taken from the cervix similar to a pap smear. Other STD's such as syphilis, hepatitis and HIV can be tested with blood samples. The cost of these depends on the lab your insurance company requires us to use and may not be covered.

Provider Signature: _____ Date: _____