

# WOMEN'S CLINIC ANNUAL EXAM FORM

Date \_\_\_\_\_

Name: \_\_\_\_\_

THIS INFORMATION IS STRICTLY CONFIDENTIAL. IF YOU ARE UNCOMFORTABLE WITH CERTAIN INFORMATION YOU MAY LEAVE IT BLANK AND DISCUSS WITH YOUR CLINICIAN AT THE TIME OF YOUR EXAM.

**Are there any health care problems or concerns you have today?**

## Personal/FamilyHistory:

Please circle: Single / Married / Divorced / Separated

Have you ever had surgery or medical problems? Y N

If yes, please describe \_\_\_\_\_

Have you or anyone in your family (parents, brothers, sisters, grandparents) had the following?

	<u>You</u>	<u>Family</u>		<u>You</u>	<u>Family</u>
Diabetes	Y N	Y N	Heart Disease/High B.P	Y N	Y N
Hepatitis	Y N	Y N	Breast Lumps(benign)	Y N	Y N
Convulsions	Y N	Y N	Thyroid Disease	Y N	Y N
Cancer	Y N	Y N	Severe Headache	Y N	Y N
Blood Clotting Disorder	Y N	Y N	Depression	Y N	Y N

Have you been immunized for Hepatitis B? Y N

Have you been immunized for Chicken Pox? Y N Had Disease

Do you smoke? If yes, how much and how long? Y N \_\_\_\_\_

Do you drink alcohol? If yes how much per week? Y N \_\_\_\_\_

Do you use any street drugs? If yes which: Y N \_\_\_\_\_

## Menstrual History:

How old were you when your periods began? \_\_\_\_\_ Date of last menstrual period \_\_\_\_\_

How many days in between periods? \_\_\_\_\_ How many days does your period last? \_\_\_\_\_

Please circle: Light / Moderate / Heavy

Do have any concerns or problems with your periods? \_\_\_\_\_

## Sexual History:

Do you consider yourself to be: Heterosexual / Lesbian / Bisexual

Have you ever had intercourse? Y N At what age did you start having sex? \_\_\_\_\_

Other types of sexual contact? Y N How many partners have you had? \_\_\_\_\_

Are you currently in a relationship? Y N How long? \_\_\_\_\_ When did you last have intercourse? \_\_\_\_\_

Do you use condoms? Y N N/A What percent of the time? \_\_\_\_\_

Do you or your partner have other partners? Y N N/A **Don't know**

Have you ever been forced to have any type of sexual contact against your will? Y N

Have you ever been in a relationship where you were physically hurt or threatened? Y N

## Contraception/Pregnancy History:

Have you ever been pregnant? Y N If Yes: Full term: \_\_\_\_\_ Miscarriages : \_\_\_\_\_ Abortions: \_\_\_\_\_

What birth control methods have you used in the past? \_\_\_\_\_

Any problems with your current method? Y N N/A \_\_\_\_\_

When was your last pap? \_\_\_\_\_

Have you ever had an abnormal pap or treatment of your cervix? Y N

If yes, explain: \_\_\_\_\_