NAME: ___________________________ DATE OF BIRTH: ________________AGE________ PRIMARY CARE MD_________________ DATE: _________

Since your last annual exam, have you had any changes in your health? ____

Do you have any questions or concerns that you would like to discuss with us today? ____

ALLERGIES: ____

YOUR GENERAL HEALTH:

Medical problems in the last year?	No	Yes_______________________
Surgeries or hospitalizations this past year?	No	Yes_______________________
Change in your family's health?	No	Yes_______________________
Do you take any medications?	No	Yes_______________________

MENSTRUAL HISTORY:

First day of last menstrual period____________ **Interval** (1st day to 1st day) ________________ # days. **Days of flow**____________

Bleeding: light, moderate, heavy **Cramps**: mild, moderate severe **Date of last Pap Smear**______________

DO YOU HAVE PROBLEMS WITH?

Fatigue/Fever	No	Yes_______________	Anxiety/Depression	No	Yes ______________________
Rash/Skin Changes	No	Yes_______________	Chest Pain/Heart Issues	No	Yes______________________
Abdominal/pelvic pain	No	Yes_______________	Breast problems	No	Yes______________________
Pain with intercourse	No	Yes_______________	Irregular bleeding/spotting	No	Yes______________________
Change in discharge	No	Yes_______________	Bladder problems	No	Yes______________________
Vulvar itching/burning	No	Yes_______________	Bowels problems	No	Yes______________________

HEALTH HABITS

Do you perform breast self-exam?	No	Yes	Date of last mammogram______________________________
Do you use a contraceptive method?	No	Yes	Pills- IUD-Tubal Ligation-Vasectomy-Condoms-Other__________________________
Do you exercise?	No	Yes	Type_________________________________
Do you smoke?	No	Yes	How much? ____________________________
Do you drink alcohol?	No	Yes	How much? ____________________________
Have you ever had a drug problem?	No	Yes	Type ________________________________
Have you had any difficulties at home?	No	Yes	____________________________________

Physician Report

WT: _____ HT: ______ BP: _______

URINE: leuc __________ glu__________ alb ________ blood_______ UPT_______

HX:

SHx

PHYSICAL EXAM

	NORMAL	FINDINGS
Skin	☐	
Heent	☐	
Thyroid	☐	
Breasts	☐	
Nipples	☐	
Axilla	☐	
Heart	☐	
Lungs	☐	
Abdomen	☐	
Lymph Nodes	☐	
Nevro	☐	
Extr	☐	
PELVIC	☐	
Ext. Gen	☐	
Urethral Meatus	☐	
Urethra	☐	
Bladder	☐	
Perineum	☐	
Vag	☐	
Cervix	☐	
Uterus	☐	
Adnexa	☐	
Anus	☐	

IMPRESSION:

PLAN:

BC STD COUNSIL PAP BSE MGM
Ca++ DEXA DIET EXERCISE
COLONOSCOPY BONE HEALTH HRT/HERBAL
BLADDER HEALTH

NEXT APPT: _____________ SIGN: ____________________