

Name: _____ Age: _____ Date: _____

Marital Status: _____ Occupation: _____ First day of your last period: _____

Primary Care MD: _____ Menopause Hysterectomy Mirena Ablation

I. **List any problems or concerns you are having:** None _____

II. List other physicians or hospitalizations you have seen **since your last visit.** None

Date	Name of Doctor/Hosp.	Problem

III. (A) Current contraception: N/A _____

(B) Current medications and dosage: (Include over-the-counter, herbal, and vitamins) None _____

(C) Medication allergies: None _____

(D) Number of sexual partners in the last year: _____ male female both

IV. Since your last visit, have you had a problem with:

	Yes	No		Yes	No		Yes	No
1. History of HPV	<input type="checkbox"/>	<input type="checkbox"/>	11. Black or bloody stools	<input type="checkbox"/>	<input type="checkbox"/>	21. Visual changes	<input type="checkbox"/>	<input type="checkbox"/>
2. Abnormal periods	<input type="checkbox"/>	<input type="checkbox"/>	12. Change in bowel habits	<input type="checkbox"/>	<input type="checkbox"/>	22. Muscle or skeletal problems	<input type="checkbox"/>	<input type="checkbox"/>
3. Bleeding between periods	<input type="checkbox"/>	<input type="checkbox"/>	13. Frequent urinary infections	<input type="checkbox"/>	<input type="checkbox"/>	23. Hepatitis, jaundice or gall bladder problems	<input type="checkbox"/>	<input type="checkbox"/>
4. Severe pain with periods	<input type="checkbox"/>	<input type="checkbox"/>	14. Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>			
5. Breast mass or lumps	<input type="checkbox"/>	<input type="checkbox"/>	15. Leakage of urine	<input type="checkbox"/>	<input type="checkbox"/>			
6. Breast secretions	<input type="checkbox"/>	<input type="checkbox"/>	16. Crushing chest pains	<input type="checkbox"/>	<input type="checkbox"/>			
7. Blood from nipples	<input type="checkbox"/>	<input type="checkbox"/>	17. Palpitations	<input type="checkbox"/>	<input type="checkbox"/>			
8. Heat or cold intolerance	<input type="checkbox"/>	<input type="checkbox"/>	18. Shortness of breath at rest	<input type="checkbox"/>	<input type="checkbox"/>			
9. Extreme fatigue	<input type="checkbox"/>	<input type="checkbox"/>	19. Change in headaches	<input type="checkbox"/>	<input type="checkbox"/>			
10. Change in skin mole	<input type="checkbox"/>	<input type="checkbox"/>	20. Severe depression	<input type="checkbox"/>	<input type="checkbox"/>			

Other: _____

V. Do you:

	Yes	No		Yes	No
Exercise regularly	<input type="checkbox"/>	<input type="checkbox"/>	Use recreational drugs	<input type="checkbox"/>	<input type="checkbox"/>
Do monthly breast exams	<input type="checkbox"/>	<input type="checkbox"/>	Smoke	<input type="checkbox"/>	<input type="checkbox"/>
Wear seatbelts	<input type="checkbox"/>	<input type="checkbox"/>	Drink alcohol	<input type="checkbox"/>	<input type="checkbox"/>
Consume at least 1000 mg/d of calcium/1000 IU Vit. D	<input type="checkbox"/>	<input type="checkbox"/>	Amount/Week _____		
Wear a helmet when biking or skiing	<input type="checkbox"/>	<input type="checkbox"/>	Have questions about domestic or sexual abuse	<input type="checkbox"/>	<input type="checkbox"/>

VI. 1. Last mammogram? N/A Where: GSBCC VRI Other: _____ Date: _____

2. Bone density/DXA? N/A Los Olivos VRI Other: _____ Date: _____

3. Colonoscopy? N/A Where? _____ Date: _____

4. Last tetanus: less than 10 years ago more than 10 years ago

VII. Family history: (include parents and siblings)

1. Family history of cancer of Breast Ovary Colon Cervix Uterus

2. Family history of: Heart attacks High cholesterol Alzheimer's Osteoporosis Hypothyroidism

3. Other illnesses: _____

How would you like to be contacted with test results? mail home phone cell phone email OK to leave results Do NOT leave results

Current email: _____ Current cell phone: _____

We are required to use a preventative care code for a well-woman annual exam when a yearly pap smear is performed. Most insurances, but not all, will cover this type of visit.