



Annual Examination

Date _____ Name _____ ID# _____

Date of Birth: _____ Age: _____

First day of last menstrual cycle: _____

Menstrual History: ___ normal ___ abnormal/describe: _____

Current Concerns: _____

Significant Changes in your Life/Health: _____

Current Prescription Medications:

- 1) _____
- 2) _____
- 3) _____
- 4) _____

Medication Allergies:

- 1) _____
- 2) _____
- 3) _____
- 4) _____

New Medical Problems: _____

New Surgical Procedures: _____

Updated Family History: _____

Current Employment: _____

Marrital Status: ___ Single ___ Married ___ Separated ___ Divorced ___ Widow

Number of Children: _____

Do you Smoke? ___ No ___ Yes: packs per day? _____

Do you drink Alcohol? ___ No ___ Yes: drinks per week? _____

Do you exercise? ___ Never ___ Occasionally ___ Often ___ Regularly

Do you have a special diet? ___ No ___ Yes: describe _____

If over 40 yrs old...

Do you have yearly mammograms? ___ No ___ Yes Date of last: _____

Have you had a Colonoscopy or Sigmoidoscopy? ___ No ___ Yes Date of last: _____

We recommend Chlamydia screening for sexually active patients between the ages of 16 and 26. Would you like this screening? ___ Yes ___ No