PARKWEST WOMEN'S HEALTH
GYN ANNUAL EXAM FORM

Name: _____ **DOB:** _____ **Date:** _____

1 MENSTRUAL HISTORY

Post Menopausal ☐ Yes ☐ No

If YES, Age at last period _____ **Then Go to Section 2**

If NO, answer remaining questions this section

What is the first day of your last period? _____

Typical number days of flow _____

Typical number of days between periods: _____

	None	Mild	Mod	Severe
Amount of flow		☐	☐	☐
Cramps	☐	☐	☐	☐
PMS	☐	☐	☐	☐
Bleeding between periods	☐	☐	☐	☐

Method of Contraception _____

2 ARE YOU EXPERIENCING ANY OF THE FOLLOWING? Please check all that apply

1	Weight Loss ☐	Weight gain ☐	Fever ☐	Fatigue ☐
2	Eye Problem ☐	Hearing Problem ☐		
3	Chest Pain ☐	Irregular Heartbeat ☐		
4	Wheezing ☐	Shortness of Breath ☐	Persistent Cough ☐	
5	Nausea/vomitting ☐	Diarrhea ☐	Bloody Stool ☐	Strain to have BM ☐
6	Abdominal pain ☐	Bloating/gas ☐		
7	Urinary Leakage ☐	Urinary Urgency ☐	Urinary Frequency ☐	Pain with urination ☐
8	Weak Stream ☐	Difficulty Voiding ☐	Incomplete Emptying ☐	
9	Blood in urine ☐	Bulge from vagina ☐		
10	Rash ☐	Bruises ☐		
11	Breast Lumps ☐	Breast Discharge ☐	Breast Pain ☐	
12	Depression ☐	Stress/Anxiety ☐	Moody ☐	
13	Painful Joints ☐	Muscle Weakness/pain ☐	Backache ☐	
14	Anemia ☐	Swollen Lymph Nodes ☐		
15	Sexually Active ☐	Not sexually active ☐	Bleeding with Intercourse ☐	
16	Vaginal dryness ☐	Loss of sexual drive ☐	Pain with Intercourse ☐	
17	Possible contact with:	Sexually Transmitted Disease ☐	Hepatitis ☐	HIV ☐

18 Do you want to be tested for Hepatitis C? ☐ Yes ☐ No 19. Do you want to be tested for HIV? ☐ Yes ☐ No

20 When was your last colonoscopy?_____ 21 When were you asked to return for next colonoscopy?

I have not had a colonoscopy ☐ ☐ 3 YRS ☐ 5 YRS ☐ 10 YRS Other_____

3 MEDICAL, FAMILY AND SOCIAL HISTORY

List any personal illnesses and/or surgery since your last annual exam:

☐ None

_____

_____

List any new serious illness in your immediate family

☐ None

_____

_____

HABITS:	Y	N	Quantity
Do you smoke:	☐	☐	
Do you consume alcohol?	☐	☐	
Do you exercise regularly?	☐	☐	
Type:			
Frequency:			
Any major changes at home?	☐	☐	

_____

_____

Patient Signature