NORTHWEST WOMEN'S HEALTHCARE

Gyn Exam Update (50+)

Name: _____ Date Of Appt: _____

Age: _____ Birth Date: _____ Preferred Pronouns: _____

Primary Care Physician: _____

DO YOU HAVE ANY QUESTIONS OR CONCERNS TODAY?

HEALTH CARE MAINTENANCE

Date of last pap smear: ___/___/_____

Result? ☐ Normal ☐ Abnormal

Have you ever had:

Mammogram? ☐ yes ☐ no If yes, when ___/___/_____

Colonoscopy? ☐ yes ☐ no If yes, when ___/___/_____

DEXA bone scan? ☐ yes ☐ no If yes, when ___/___/_____

When did you last have your cholesterol checked? ___/___/_____

FOR DOCTORS USE ONLY

GYN UPDATE

Are you still having menstrual cycles?	☐ yes	☐ no
Date of last menstrual cycle: ___/___/_____		
Are you sexually active?	☐ yes	☐ no
Are you having postmenopausal bleeding?	☐ yes	☐ no
Are you having hot flashes?	☐ yes	☐ no
Are you experiencing vaginal dryness?	☐ yes	☐ no
Are you having irritability or insomnia?	☐ yes	☐ no
Are you currently on any hormones?	☐ yes	☐ no

FOR DOCTORS USE ONLY

Any changes in your medical history?

Have you had any surgery since your last annual exam?

Any changes in your family history?

SOCIAL HISTORY

Are you: ☐ Single ☐ In a relationship ☐ Married ☐ Partnered ☐ Divorced ☐ Other

Occupation :_____ Any Job Changes? _____

DO YOU:	YES	NO
Smoke tobacco products?	☐	☐
Drink alcohol?	☐	☐
How many drinks per week?		
☐ 0 ☐ 1-5 ☐ 5-10 ☐ >10		
Use marijuana?	☐	☐
Use other recreational drugs?	☐	☐
Have a history of abuse or trauma?	☐	☐
Suffer ongoing abuse or trauma?	☐	☐

	YES	NO
Feel safe?	☐	☐
Wear your seatbelt?	☐	☐
Exercise regularly?	☐	☐
Have guns in the home?	☐	☐
If so, are they secured?	☐	☐
Religious preference? _____		

REVIEW OF SYSTEMS

Do you currently have any of the following symptoms?

- ☐ Body aches
- ☐ Fatigue
- ☐ Night sweats
- ☐ Impaired vision
- ☐ Headaches
- ☐ Breast lumps
- ☐ Nipple tenderness or discharge
- ☐ Chest pain
- ☐ Fainting
- ☐ Irregular heart beat
- ☐ Shortness of breath
- ☐ Cough
- ☐ Wheezing
- ☐ Nausea/Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Blood in stools
- ☐ Urinary incontinence
- ☐ Discomfort with urination
- ☐ Skin rash
- ☐ Numbness
- ☐ Joint pain
- ☐ Heat/cold intolerance
- ☐ Depression
- ☐ Anxiety
- ☐ Easy bleeding/bruising
- ☐ Seasonal allergies

MEDICATIONS

Please list current medications, doses, instructions (include vitamins and supplements)

MEDICATION	DOSE	FREQUENCY

Medication allergies (and reaction)

_____

_____

_____

PATIENT SIGNATURE: _____ **DATE:** _____