NORTHWEST WOMEN'S HEALTHCARE

Gyn Exam Update

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 ___/___/_____

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

FOR DOCTORS USE ONLY

GYN UPDATE

Date of last menstrual cycle: ___/___/_____

Are your cycles regular?	☐ yes	☐ no
Are you sexually active?	☐ yes	☐ no
Any new partners since your last visit?	☐ yes	☐ no
Would you like an STD screen today?	☐ yes	☐ no
Are you currently using birth control?	☐ yes	☐ no
What do you use?		
Are you satisfied with this method?	☐ yes	☐ no
Are you currently trying to get pregnant?	☐ yes	☐ no
If yes, for how long have you been trying?		

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?

- ☐ Fever
- ☐ Fatigue
- ☐ Night sweats
- ☐ Headaches
- ☐ Breast lumps
- ☐ Breast tenderness
- ☐ Nipple discharge
- ☐ Chest pain
- ☐ Irregular heart beat
- ☐ Shortness of breath
- ☐ Indigestion/Heartburn
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Urinary frequency
- ☐ Discomfort with urination
- ☐ Pelvic pain
- ☐ Cramping
- ☐ Unusual vaginal discharge
- ☐ Rash
- ☐ 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: _____