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ANNUAL FEMALE HEALTH EXAM

Name _____ DOB _____ Today's Date _____

1. When was your last **normal** menstrual period? _____
2. If you are menopausal, what age were you when you had your last period?_____
3. Have often do you have your period?_____
4. How long does your period last?_____
5. Do you have any problems related to your periods?_____
6. How old were you when you had your first period?_____

13. How many pregnancies have you had?___
    a. How many live births _____
    b. How many abortions (spontaneous or induced) _____
14. When was your last pap? _____
15. Have you ever had an abnormal pap?____
    a. If yes, when?_____
16. When was your last mammogram? _____
17. Have you ever had an abnormal mammogram? _____
    a. If yes, when? _____
18. Do you lose urine when you cough, laugh or sneeze?_____
19. Are you sexually active? _____
    a. If yes, circle all that apply
        with women
        with men
        with men who have sex with men
20. Are you using contraception?_____

7. Are you planning on becoming pregnant in the next 6-12 months? _____
    a. If yes, when _____
8. Have you had any abdominal surgeries? If yes, what surgery & when?
    _____
    _____
9. Have you had any gynecologic surgery? If yes, what surgery & when?
    _____
    _____
10. Have you ever been treated for a sexually transmitted disease? If yes, for what & when?
    _____
    _____
11. Do you have any sexual concerns?_____
12. Do you have any other concerns?_____

Please check whether you or a family member has had any of the following:

Condition	**You**	**Family Member**
Breast Cancer		
Uterine Cancer		
Cervical Cancer		
Ovarian Cancer		
Osteoporosis		
Endometriosis		
Thyroid Problems		