### Patient section

Please answer the following questions. This will help your physician identify possible problems.

- **Your age:** __________
- **When was your last period?** ________________
- **When was your last mammogram?** ________________
- **When was your last Pap test?**
  - [ ] 1 yr
  - [ ] 2 yrs
  - [ ] >3 yrs
- **Were the results normal?**
  - [ ] Yes
  - [ ] No
- **Have you ever had an abnormal Pap test?**
  - [ ] Yes
  - [ ] No
- **How many days do your periods usually last?** _____________
- **Are your periods usually regular?**
  - [ ] Yes
  - [ ] No
- **How often do you usually get your period?** every ________ days
- **How many days do your periods usually last?** ________________
- **The blood flow is:**
  - [ ] Light
  - [ ] Moderate
  - [ ] Heavy
- **Do you have any bleeding between periods?**
  - [ ] Yes
  - [ ] No
- **Do you have any vaginal discharge?**
  - [ ] Yes
  - [ ] No
- **Are you sexually active?**
  - [ ] Yes
  - [ ] No
  - If yes, do you and your partner use birth control?
    - [ ] Yes
    - [ ] No
  - Method: ____________________________
- **Have you ever had a sexually transmitted disease?**
  - [ ] Yes
  - [ ] No
- **Has your mother ever been exposed to DES?**
  - [ ] Yes
  - [ ] No
- **Have you used fertility medicines?**
  - [ ] Yes
  - [ ] No
- **Do you have hot flashes?**
  - [ ] Yes
  - [ ] No
- **Do you have any allergies?**
  - [ ] Yes
  - [ ] No
- **Do you smoke?**
  - [ ] Yes
  - [ ] No
- **How often do you perform self breast-exams?**
  - [ ] Less often than monthly
  - [ ] Monthly
- **Do you have a history of breast problems?**
  - [ ] Yes
  - [ ] No
- **Have you ever been abused?**
  - [ ] Yes
  - [ ] No
- **Do you feel safe?**
  - [ ] Yes
  - [ ] No
- **Is there any family history of:**
  - Breast cancer:
    - [ ] Yes
    - [ ] No
  - Osteoporosis:
    - [ ] Yes
    - [ ] No
  - Colon cancer:
    - [ ] Yes
    - [ ] No
  - Ovarian cancer:
    - [ ] Yes
    - [ ] No
  - Diabetes:
    - [ ] Yes
    - [ ] No
  - Uterine cancer:
    - [ ] Yes
    - [ ] No
  - Heart disease:
    - [ ] Yes
    - [ ] No
  - Other cancers:
    - [ ] Yes
    - [ ] No
- **Do you have any allergies?**
  - [ ] Yes
  - [ ] No
  - (list them below)

On a scale of 0 to 10, with 0 being no symptoms and 10 being severe symptoms, how would you describe the following (please circle):

- **Pain during your usual period:**
  - [ ] 0
  - [ ] 1
  - [ ] 2
  - [ ] 3
  - [ ] 4
  - [ ] 5
  - [ ] 6
  - [ ] 7
  - [ ] 8
  - [ ] 9
  - [ ] 10
- **Pain during sex:**
  - [ ] 0
  - [ ] 1
  - [ ] 2
  - [ ] 3
  - [ ] 4
  - [ ] 5
  - [ ] 6
  - [ ] 7
  - [ ] 8
  - [ ] 9
  - [ ] 10
- **PMS (premenstrual tension syndrome):**
  - [ ] 0
  - [ ] 1
  - [ ] 2
  - [ ] 3
  - [ ] 4
  - [ ] 5
  - [ ] 6
  - [ ] 7
  - [ ] 8
  - [ ] 9
  - [ ] 10

If you have been pregnant, please indicate how many:

- **Pregnancies:** ____________
- **Miscarriages:** ____________
- **Abortions:** ____________
- **Living children:** ____________
- **Full-term live births:** ____________
- **Premature births:** ____________

Please list any other concerns: ____________________________

### Physician section

Abnormals should be described below or on the reverse side of this form. See separate note in chart.

<table>
<thead>
<tr>
<th>Abnormality</th>
<th>Normal</th>
</tr>
</thead>
<tbody>
<tr>
<td>HEENT</td>
<td>ABDOMEN</td>
</tr>
<tr>
<td>THYROID</td>
<td>SKIN</td>
</tr>
<tr>
<td>LUNGS</td>
<td>EXTREMITIES</td>
</tr>
<tr>
<td>HEART</td>
<td>NEURO</td>
</tr>
</tbody>
</table>

If there are any abnormalities, circle the specific one(s) and describe below or on reverse.

<table>
<thead>
<tr>
<th>Abnormality</th>
<th>Normal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breasts</td>
<td>Masses</td>
</tr>
<tr>
<td>Lumps</td>
<td>Tenderness</td>
</tr>
<tr>
<td>Symmetry</td>
<td>Nipple discharge</td>
</tr>
<tr>
<td>Axilla</td>
<td></td>
</tr>
<tr>
<td>External genitalia</td>
<td>Appearance</td>
</tr>
<tr>
<td>Hair distribution</td>
<td>Lesions</td>
</tr>
<tr>
<td>Urethra &amp; Meatus</td>
<td>Size</td>
</tr>
<tr>
<td>Location</td>
<td>Lesions</td>
</tr>
<tr>
<td>Prolapose</td>
<td>Masses</td>
</tr>
<tr>
<td>Tenderness</td>
<td>Scarring</td>
</tr>
<tr>
<td>Vagina</td>
<td>Appearance</td>
</tr>
<tr>
<td>Discharge</td>
<td>Lesions</td>
</tr>
<tr>
<td>Estrogen effect for age/meds</td>
<td>Pelvic support</td>
</tr>
<tr>
<td>Cystocele</td>
<td>Rectocele</td>
</tr>
<tr>
<td>Cervix</td>
<td>Appearance</td>
</tr>
<tr>
<td>Lesions</td>
<td>Discharge</td>
</tr>
<tr>
<td>Uterus</td>
<td>Size</td>
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<tr>
<td>Contour</td>
<td>Position</td>
</tr>
<tr>
<td>Mobility</td>
<td>Tenderness</td>
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<tr>
<td>Consistency</td>
<td>Support</td>
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<tr>
<td>Adnexa</td>
<td>Masses</td>
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<tr>
<td>Tenderness</td>
<td>Organomegaly</td>
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<tr>
<td>Nodularity</td>
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<tr>
<td>Bladder</td>
<td>Fullness</td>
</tr>
<tr>
<td>Masses</td>
<td>Tenderness</td>
</tr>
<tr>
<td>Anus &amp; Perineum</td>
<td></td>
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<tr>
<td>Rectal</td>
<td>Tone</td>
</tr>
<tr>
<td>Hemorrhoids</td>
<td>Masses</td>
</tr>
<tr>
<td>Hemoccult</td>
<td></td>
</tr>
<tr>
<td>KOH/Wet Prep</td>
<td></td>
</tr>
<tr>
<td>Acetic Acid Wash</td>
<td></td>
</tr>
</tbody>
</table>

A: [ ] Normal gyn/pap [ ] Family planning [ ] Pregnancy [ ] HRT
P: [ ] Pap [ ] HRT info given [ ] Caffeine ed [ ] Stool OB
[ ] STD screen [ ] Diet/Exercise [ ] HPV vaccine [ ] Tdap
[ ] BSE info [ ] Flex Exercise [ ] Calcium ed [ ] Flu shot
[ ] Mammogram [ ] Dexa [ ] Heel [ ] Full

Return for pap/well woman: 1 year _____ 3 year _____ RTC _____