ANNUAL MEDICAL EXAM RECORD FOR WOMEN 50 YEARS AND OLDER

Patient Name__________________________ Birth Date__________ Age____ Patient Number__________

MEDICAL HISTORY	YES	NO
A. Have you seen a doctor since your last visit with us? If so, for what and when?		
B. Has any family member had a serious illness or death this past year? If so, who and what?		
C. Any surgeries or hospitalizations this year? What and when?		
D. List any conditions that you are presently being treated for:		

CURRENT MEDICAL PROBLEMS	YES	NO
A. Breast problems?		
B. Problems with urination?		
C. Abnormal weight gain or loss in last year?		
D. Problems with abdominal/stomach pain/rectal bleeding?		
E. Current problems with depression?		
F. Chest pain, shortness of breath, swelling in legs?		
G. Severe headaches?		
H. Any concerns about physical or sexual abuse?		
I. Do you smoke? If yes,__________ packs per day		
J. Do you drink alcohol? If yes, what__________ amount per week?		
K. Do you use "street" drugs? If yes, what__________ how much/week?		

MEDICATIONS

List all medications you are taking now. (Include viatmins, prescription drugs, and over-the-counter medication)

Allergies to Medications

☐ **NKA**

GYNECOLOGICAL HISTORY	YES	NO
A. Are you still having periods? _____ yes _____no If yes, any problems with your period?		
B. If you are post menopausal, have you had any bleeding this year?		
C. Are you having sex? _____yes _____no If yes, any pain or problems?		
D. Do you need birth control today or hormone replacement therapy?		
E. Is there any family history of breast, cervical, uterine, colon or ovarian cancer?		
F. Any current vaginal discharge, odor or infections?		
G. Any questions or concerns today?		

Last pelvic exam_____/_____/_____ Number of times pregnant________ Number of births________

PATIENT SIGNATURE:______________________________ **DATE:**__________

STAFF NOTES

Staff Signature/Title: ______________________________ **Date**__________