ALL INFORMATION IS CONFIDENTIAL

INITIAL/ANNUAL PATIENT HISTORY

Patient Name	Birthdate	Age	Clinic #	Patient Number

MEDICAL HISTORY

DO YOU NOW HAVE OR HAVE YOU EVER HAD:	YES	NO
a. Dizziness/blurred vision/severe or migraine headaches		
b. Epilepsy/convulsive seizures (fits)		
c. Nervous breakdown/fatique/depression/emotional problems		
d. Lung problems/asthma/coughing blood/mucus		
e. Nagging cough or hoarseness		
f. Thyroid problems		
g. Heart problems/rheumatic fever/chest pains/shortness of breath		
h. High blood pressure/stroke/high blood fat/cholesterol		
i. Blood clots in legs/varicose veings (swollen veins)/numbness		
j. Liver problems (jaundice, mononucleosis, hepatitis)		
k. Gall bladder problems		
l. Indigestion or difficulty in swallowing		
m. Obesity/weight gain/weight loss (How much in how long?)		
n. Nutritional problems/bone or joint disease		
o. Kidney/bladder/urination problems or infections		
p. Change in bowel or bladder habits		
q. Colitis/polyps in colon or rectum/bleeding from rectum/frequent black stool		
r. Ever had proctoscopic exam? (When?)		
s. Ovary/uterus or womb problems or P.I.D./uterine fibroids		
t. Diabetes (sugar blood/urine)		
u. German measles (3-day/rubella) or immunization		
v. Anemia/Bleeding disorder		
w. Breast problems		
x. Thickening or lump in breast or elsewhere/breast pain or tenderness		
y. Breast dimpling/puckering/nipple discharge or change in appearance		
z. Cancer (what type?)		
Are you currently being treated?		
aa. History of genetic abnormalities		
bb. Recent fever		
cc. Allergies (what type?)		
dd. Vaginal infections/sores in vagina/vaginal dryness		
ee. STD/veneral disease (VD, gonorrhea, syphilis, herpes, veneral warts)		
ff. Hot flushes/flashes/uncomfortable menopause symptoms		
gg. Fluid retention/legs or arms swelling/pain		
hh. Sore that does not heal		
ii. Obvious change in wart or mole		
jj. Do you smoke cigarettes? (Pks. per day?) (Duration)		
kk. Daily use of alcohol/drugs		
ll. Have you ever been hospitalized or had surgery?		
mm. Do you have other medical problems?		

FAMILY HISTORY

DOES YOUR NATURAL MOTHER, FATHER, SIS., BRO., OR GRANDPARENTS HAVE OR HAVE THEY EVER HAD ANY OF THE FOLLOWING (If yes, specify whom):	YES	NO
a. Diabetes (sugar blood/urine)		
b. Heart attack or disease/high blood pressure/stroke		
c. Family history of high blood fat/cholesterol		
d. Blood clots/varicose veins (swollen veins)		
e. **Family history of polyps in colon or rectum/colorectal cancer**		
f. **Cancer (specify type**)		
g. Family history of osteoporosis		
h. Mother took drug, hormones or DES while pregnant		

MEDICATION HISTORY

List all medications you are taking now. Include prescription drugs, vitamins, and hormone therapy:

CONTRACEPTIVE HISTORY

Current method of birth control used ______________ Not applicable ______________

How long have your been using this method ______________

List any past methods used and any problems with them: ______________

____

____

PREGNANCY HISTORY

Number of times pregnant ______________ Age at first pregnancy ______________

Could you be pregnant now? Yes ☐ No ☐ I don't know ☐

Have you ever tried to get pregnant and couldn't? Yes ☐ No ☐

Number of live births still living ______________

COMPLETE THE FOLLOWING TABLE FOR EACH PREGNANCY

Date Pregnancy Ended	Problems with Pregnancy or Delivery (stillbirth, toxemia, other)	Weight of Baby	No. Months Pregnant	Caesarean Section (✓)	Mis-Carriage (✓)	Abortion (✓)

GYNECOLOGICAL/MENSTRUAL HISTORY

a. Date and result of last pap smear ________ / ________ / ________ Normal ☐ Abnormal ☐

b. Date and result of last pelvic exam ________ / ________ / ________ Normal ☐ Abnormal ☐

c. Date and result of last mammogram ________ / ________ / ________ Normal ☐ Abnormal ☐

d. First day of last or current period ________ / ________ / ________

e. Age period began ________ f. Age period stopped ________

g. Age at first intercourse: ________ Before age 18 ________ After age 18

h. Total number of days you flow ________

i. Amount of flow: Heavy ________ Medium ________ Light ________

j. Number of days between period (first day to first day) ________

k. Number of sexual partners: ________ 0-5 ________ 6+

		YES	NO
l.	Do you examine your breasts?		
m.	Are you currently having sexual intercourse?		
n.	**Have you had previous abnormal pap smears?**		
o.	Are your periods regular?		
p.	Do you have cramps or pain with your period?		
q.	Have you missed a period within the last 6 months?		
r.	**Do you have abnormal bleeding?**		
s.	Do you have any unusual vaginal discharge?		
t.	Do you have pain or bleeding during or after sex?		
u.	Do you douche?		

CLINIC NOTES

Reason for Visit: ________________________________

Clinic Staff Signature ________________________________ Date ______/______/______

PATIENT SIGNATURE

____

________________________________ Date ______/______/______

MEDICAL EXAMINATION RECORD

Initial	Annual	6 mo.	Age	Date of Visit	Patient Name

COUNSELING EDUCATION

CHECK COUNSELING/EDUCATION PROVIDED:

- Breast cancer education ☐
- Cervical cancer education ☐
- Colorectal cancer education ☐
- Smoking cessation education ☐
- Menopause ☐
- Other (Specify): ☐

	YES	NO
Has patient demonstrated understanding of education?		
Is follow-up counseling/education necessary?		

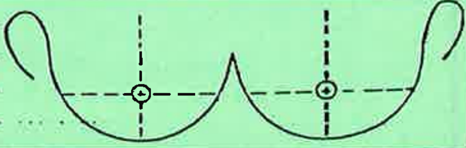
Patient's Choice or Method:

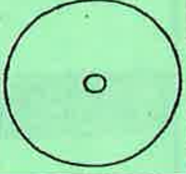
Notes:

Counselor Signature:

PHYSICAL EXAMINATION

PHYSICAL EXAMINATION	Normal (✓)	Ab-Normal (✓)	Comments and Additional Data
Weight (Abnormal if appears obese)			Specify wt.:
Height			Specify ht.:
Blood Pressure			Specify BP:
Skin/Hair Distribution			
Breasts			
Cardiorespiratory (in detail if indicated)			
Thyroid			
Abdomen			
Extremities			
Neurologic (in detail if indicated)			
External Genitalia			Discharge
Vagina			
Cervix			
Uterus: Size/Shape			Position
Adnexae			
Rectovaginal			
Other physical findings (specify):			





LABORATORY

LABORATORY	Ordered/Provided (✓)	Normal (✓)	Ab-Normal (✓)	Results and Dates (if not current)			
Hct or High							
Urine Chemistry				Protein	Sugar		
Vaginal Smear					Date of Result		
Pap Smear					mo.	day	yr.
Hemoccult					mo.	day	yr.
Other (Specify):					mo.	day	yr.

PLAN

Brand (dose, size, lot #, etc.)

Special instructions/comments

FDA Labeling Provided: ☐ Yes ☐ No

Treatment/Referrals: (list all medications given or prescribed and referrals made):

Return interval to family planning:	Next Appointment:	Clinician Signature:

CLINIC NOTES