

# ANNUAL MEDICAL EXAM RECORD

--	--	--



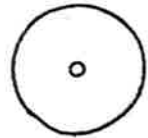
Date of Visit

Patient Name

Age

COUNSELING/EDUCATION				Yes	No
	Discussed	Materials	Has patient demonstrated understanding of counseling/education?	<input type="checkbox"/>	<input type="checkbox"/>
Method Review/Proper Use	<input type="checkbox"/>	<input type="checkbox"/>	Is follow-up counseling/education necessary?	<input type="checkbox"/>	<input type="checkbox"/>
Method Change Education	<input type="checkbox"/>	<input type="checkbox"/>	Is patient satisfied with her current method?	<input type="checkbox"/>	<input type="checkbox"/>
Special Education/Adolescents	<input type="checkbox"/>	<input type="checkbox"/>	NOTES:		
Reinforce STD/HIV Prevention	<input type="checkbox"/>	<input type="checkbox"/>	<p>Immunizations      Yes      No      BMI _____</p> <p>Signature/Title: _____</p>		
Emergency Contact Procedures	<input type="checkbox"/>	<input type="checkbox"/>			
Reinforce Breast Self Exam	<input type="checkbox"/>	<input type="checkbox"/>			
Emergency Contraception	<input type="checkbox"/>	<input type="checkbox"/>			
Problems Conceiving a Child	<input type="checkbox"/>	<input type="checkbox"/>			
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>			

LABORATORY	DONE	REFUSED	WNL	DESCRIPTION/RESULTS
Vital Signs				Weight:                      Height:                      Blood Pressure:
Hct or Hgb				As appropriate:
Pap Smear				
Chlamydia Test				
GC Culture				
Vaginal Smear				
Pregnancy Test				Negative:                      Positive:
Other (e.g. Urine Chemistry):				

PHYSICAL EXAMINATION	TAK	ABN	WNL	COMMENTS AND ADDITIONAL DATA
Skin/Hair Distribution				
Breasts				
Cardiorespiratory				
Thyroid				
Abdomen				
Extremities				
External Genitalia				
Vagina (discharge)				
Cervix				
Uterus: Size/Shape/Position				
Adnexum				
Rectal (If Indicated)				
Other physical findings (specify):				

**ASSESSMENT SUMMARY/MEDICAL PLAN/TREATMENT:**

# ANNUAL PATIENT HISTORY FORM

Patient Name

Birthdate

Age

Clinic

Patient Number

MEDICAL HISTORY UPDATE		Yes	No
a. Have you seen a doctor or sought medical care since your last exam?			
b. Any serious illnesses or deaths in your natural family since your last exam?			
c. Do you smoke? If yes, amount/day:			
d. Do you use drugs? If yes, amount/week:			
e. Do you drink alcohol? If yes, amount/week:			
f. Depression/mood swings in the past year?			
ARE YOU HAVING OR HAVE YOU HAD ANY OF THE FOLLOWING (if yes, circle type)	Yes	No	
g. Abdominal pain/nausea			
h. Chest pain/shortness of breath			
i. Severe headaches/changes-in-vision			
j. Pain/tingling/swelling (hands, legs, feet)			
k. Do you have any concerns about abuse/force (sexual, physical, or emotional)?			
l. Urinary problems			
<b>MEDICATION HISTORY:</b> List all medications you are taking now (include prescription drugs, vitamins, and herbal medication):			
List Medication and/or Latex Allergies: <input type="checkbox"/> None Known			

PREGNANCY HISTORY		Yes	No	
a. Number of times pregnant _____				
Number of living children _____				
b. Could you be pregnant now?				
c. Are you planning to become pregnant in the next 2 years?				
<b>COMPLETE THE FOLLOWING TABLE FOR EACH PREGNANCY SINCE YOUR LAST EXAM</b>				
Date Pregnancy Ended	Problems with Pregnancy	Wt. of Baby	No. Weeks Pregnant	Type of Delivery
1.				
2.				

GYNECOLOGICAL HISTORY	
a. First day of last or current period ____/____/____	
ARE YOU HAVING OR HAVE YOU HAD ANY OF THE FOLLOWING (if yes, circle problem)	
b. Do you examine your own breasts? <input type="checkbox"/> Yes <input type="checkbox"/> No	
c. Cramps? <input type="checkbox"/> Yes <input type="checkbox"/> No	
d. Bleeding/spotting between periods? <input type="checkbox"/> Yes <input type="checkbox"/> No	
e. Pain/Bleeding during Intercourse? <input type="checkbox"/> Yes <input type="checkbox"/> No	
f. STD? (chlamydia, gonorrhea, herpes, warts, HIV/AIDS) <input type="checkbox"/> Yes <input type="checkbox"/> No	
g. Unusual vaginal discharge/odor/genital sores? <input type="checkbox"/> Yes <input type="checkbox"/> No	
h. Does your partner use condoms? <input type="checkbox"/> Yes <input type="checkbox"/> No	
i. How many sex partners have you had in the last year? _____	
Partners are: _____ Male _____ Female _____ Both	
j. Type of sexual contact <input type="checkbox"/> Vaginal <input type="checkbox"/> Mouth <input type="checkbox"/> Anal	
k. Is there anything that runs in your family or your partners family that concerns you about having children? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, would you like genetic information? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Referred to: _____	
l. Current Birth Control Method: _____	
Any problems with it? <input type="checkbox"/> Yes <input type="checkbox"/> No	
m. Please respond:	OK    NOT OK    NEVER
Date of last Mammogram ____/____/____	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Date and result of last Pelvic ____/____/____	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Date and result of last Pap Tests ____/____/____	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<b>All information is Confidential</b>	
Patient's Signature: _____	
Date: ____/____/____	

STAFF NOTES	
Signature/Title _____	Date _____