ANNUAL MEDICAL EXAM RECORD

Date of Visit	Patient Name	Age

COUNSELING/EDUCATION

	Discussed	Materials
Method Review/Proper Use	☐	☐
Method Change Education	☐	☐
Special Education/Adolescents	☐	☐
Reinforce STD/HIV Prevention	☐	☐
Emergency Contact Procedures	☐	☐
Reinforce Breast Self Exam	☐	☐
Emergency Contraception	☐	☐
Problems Conceiving a Child	☐	☐
Other: ______________________	☐	☐

	Yes	No
Has patient demonstrated understanding of counseling/education?	☐	☐
Is follow-up counseling/education necessary?	☐	☐
Is patient satisfied with her current method?	☐	☐

NOTES:

Immunizations **Yes** **No**

BMI ____________

Signature/Title: ______________________________

LABORATORY

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

PHYSICAL EXAMINATION	N/A	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:

Return Interval: ______________ Clinician Signature/Title: ______________________________

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		

MEDICATION HISTORY: List all medications you are taking now (include prescription drugs, vitamins, and herbal medication):

List Medication and/or Latex Allergies: ❑ 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?		

. COMPLETE THE FOLLOWING TABLE FOR EACH PREGNANCY SINCE YOUR LAST EXAM

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? ❑ Yes ❑ No

c. Cramps? ❑ Yes ❑ No

d. Bleeding/spotting between periods? ❑ Yes ❑ No

e. Pain/Bleeding during Intercourse? ❑ Yes ❑ No

f. STD? (chlamydia, gonorrhea, herpes, warts, HIV/AIDS) ❑ Yes ❑ No

g. Unusual vaginal discharge/odor/genital sores? ❑ Yes ❑ No

h. Does your partner use condoms? ❑ Yes ❑ No

i. How many sex partners have you had in the last year? ______

Partners are: ______ Male ______ Female ______ Both

j. Type of sexual contact ❑ Vaginal ❑ Mouth ❑ Anal

k. Is there anything that runs in your family or your partners family that concerns you about having children? ❑ Yes ❑ No

If yes, would you like genetic information? ❑ Yes ❑ No

Referred to ______

l. Current Birth Control Method: ______

Any problems with it? ❑ Yes ❑ No

m. Please respond:	OK	NOT OK	NEVER
Date of last Mammogram ____/____/____	❑	❑	❑
Date and result of last Pelvic ____/____/____	❑	❑	❑
Date and result of last Pap Tests ____/____/____	❑	❑	❑

All information is Confidential

Patient's Signature: ______

Date: ______ / ______ / ______

STAFF NOTES

Signature/Title Date