Annual Women's Health Form

NAME:_____ DOB:_____ DATE:_____

Last menstrual period:_____ Normal Abnormal Menopause

Sexually active (circle one) Yes No **Partners** (circle one): One More than one

Birth control (circle one)**:** Yes No **Type:** _____

Sexually Transmitted Disease History

Gonorrhea	Yes	No
Chlamydia	Yes	No
Herpes	Yes	No
Genital Warts	Yes	No
Syphilis	Yes	No
HIV	Yes	No

History of Previous Medical Conditions:

Endometriosis	Yes	No
Fibroids	Yes	No
Ovarian Cyst	Yes	No
Infertility	Yes	No

Have you ever been pregnant (circle one)**?** Yes No

If yes, how many times have you been pregnant:_____ How many births:_____

Last pap exam:_____ Normal Abnormal

If abnormal, what other tests or procedures have you had:_____

Last mammogram:_____ Normal Abnormal

Tobacco use (circle one)**:** Yes No

Alcohol use (circle one)**:** Yes No If yes (circle one): Rarely Daily

If over 50, have you had a Colonoscopy? Yes No If yes, date:_____

Immunization History

Tetanus in last 10 years	Yes	No
Pneumonia vaccine	Yes	No
Flu shot in last 1 year	Yes	No

Are you fasting for blood work today (circle one)? Yes No