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

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