Natural Health Clinic of Olympia • 3624 Ensign Rd. NE Suite B • Olympia, WA 98506 • 360-491-4131

Women’s Annual Exam Form

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any concerns with this exam?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last Pap smear?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ever had an abnormal Pap? \_\_Yes (date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_treatment\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) \_\_No

Age your periods began\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you no longer have periods, when was your last one?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many days between the first day of one period and the first day of the next?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many days does the flow last?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Average flow: \_\_Light \_\_Medium \_\_Heavy

Missed Periods: \_\_Never \_\_Rarely \_\_Occasionally \_\_Frequently

Spotting between periods: \_\_Yes \_\_No

First day of last menstrual period:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Menstrual symptoms:

\_\_Clots \_\_Cramps (if yes, please describe when and how long)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_Bloating \_\_Breast tenderness \_\_Emotional changes \_\_Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications used for menstrual symptoms\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you sexually active? \_\_Yes \_\_Not currently \_\_Never

Are you experiencing any pain or discomfort with sex? \_\_Yes \_\_No

What is your method of birth control?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been diagnosed with any of the following? (If yes, please give date):

\_\_Chlamydia\_\_\_\_\_\_\_\_\_\_

\_\_Hepatitis B\_\_\_\_\_\_\_\_\_\_

\_\_Syphilis ­\_\_\_\_\_\_\_\_\_\_

\_\_HIV ­\_\_\_\_\_\_\_\_\_\_

\_\_Genital Herpes­\_\_\_\_\_\_\_\_\_\_

\_\_Gonorrhea \_\_\_\_\_\_\_\_\_\_

\_\_Genital warts \_\_\_\_\_\_\_\_\_\_

Do you have a history of frequent yeast infections? \_\_Yes \_\_No

Do you have a history of frequent urinary tract infections? \_\_Yes \_\_No

Do you have urgent urination or leaking urine? \_\_Yes \_\_No

Specify number of:

Pregnancies: \_\_\_\_ Children born alive: \_\_\_\_ Miscarriages: \_\_\_\_ Abortions: \_\_\_\_ Ectopic: \_\_\_\_

Vaginal deliveries: \_\_\_\_\_ Cesarean deliveries: \_\_\_\_\_

Date of last delivery:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_