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_____	__HIV _____
__Hepatitis B_____	__Genital Herpes_____
__Syphilis _____	__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:_____