NAME:		DOB:		DATE:	

REASON FOR VISIT: Annual/ Well Woman Exam

Please indicated below any changes that occurred since your last Annual Exam	☐ Check here and initial if no Changes since last Annual Exam Patient Initials: _____

PAST PERSONAL & FAMILY MEDICAL HISTORY: **PLEASE CHECK IF YOU (PERS) OR A BLOOD RELATIVE (FAM) HAD ANY OF THE FOLLOWING CONDITIONS:**

P=Paternal / F= Father, M=Maternal or Mother, U=Uncle, A=Aunt, GM=Grandmother, GF=Grandfather, S=Sister, B=Brother, i.e., PA = Paternal Aunt, or MGF = Maternal Grandfather, or F=Father, or M=Mother

ILLNESS / DISEASE	PERS	FAM	ILLNESS / DISEASE	PERS	FAM
i.e., Cancer *Colon*	☐	☒ *M, S*	15. Blood Transfusion	☐	
1. Weight Loss / Gain	☐		16. Anemia / Blood Disorder	☐	
2. Headache/ Migraine	☐		17. Varicose Veins / Phlebitis	☐	
3. Heart ☐ Valvular Dis☐ Disease Rheumatic Dis ☐	☐	☐_____	18. Skin Disease	☐	☐_____
4. High Blood Pressure	☐	☐_____	19. Diabetes	☐	☐_____
5. High Cholesterol	☐	☐_____	20. Thyroid Disease	☐	☐_____
6. Respiratory Disease Pulmonary (Lung)	☐	☐_____	21. Cancer (Type)_____	☐	☐_____
7. Breast Disease	☐	☐_____	22. Epilepsy / Neurological Dis	☐	☐_____
8. Jaundice / Hepatitis	☐	☐_____	23. Arthritis-Joint Pain	☐	☐_____
9. Hiatal Hernia (Reflux)	☐	☐_____	24. Osteoporosis (Fragile Bones)	☐	☐_____
10. Peptic Ulcer (Stomach)	☐	☐_____	25. Anxiety / Depression	☐	☐_____
11. Bowel Disease	☐	☐_____	26. Sleep Problems	☐	☐_____
12. Kidney Disease	☐	☐_____	27. Endometriosis	☐	☐_____
13. Urinary Incontinence	☐	☐_____	28. Fibroids	☐	☐_____
14. Urinary Infection	☐	☐_____	29. Infertility	☐	☐_____

SURGERIES, HOSPITALIZATIONS, OR GYNECOLOGIC PROCEDURES (INCLUDING PREGNANCIES)

Year	Reason for Hospital Admission / Surgery Type	Year	Reason for Hospital Admission / Surgery Type

SOCIAL HISTORY	**SMOKING** - ☐Y ☐N # of Cig Day	# of Years	Quit Yes No	**ALCOHOL** Drinks/Day	**CAFFEINE** Drinks/Day	**RECREATIONAL DRUGS** ☐Yes ☐No	**EXERCISE** Days/Wk

MENSTRUAL / MENOPAUSAL HISTORY	Age at 1st Period_____	1st date of last period_____	# of days period last_____	# of days btwn period_____	Are they monthly? ☐Y ☐N

Cramps ☐Y ☐N	☐Mild ☐Mod	☐Severe ☐Always present	Medications for Cramps ☐Y ☐N	**Age of Last Menses**	Hot Flashes ☐Y ☐N Treatment:

OBSTETRICAL HISTORY Number Of Pregnancies_____ Miscarriages_____ Live Births_____

MEDICATIONS (INCLUDING OVER THE COUNTER DRUGS/HERBAL SUPPLEMENTS/VITAMINS)

DRUG ALLERGIES					
LAST PAP	Date:	Normal ☐Y☐N	LAST MAMMOGRAM / BONE DENSITY	Date:	Normal ☐Y☐N

Austin Gyn Associates does not collect urine samples as part of an Annual Exam.