Capital Women's Care

ANNUAL EXAM REVIEW

NAME: _____ PREFERRED NICK NAME: _____

DOB: AGE: EMAIL: DATE:

Primary Care Physician: _____ Ph: _____

Birth Control: Method Currently Used _____ How long? _____

Periods:	Breast (currently):
• Date of last menstrual period _____ • How often do you get your period (Every how many days)? _____ • Periods last ___number of days; painful No ( ) Yes ( ) • Any medications used: _____ • Do the medications relieve your pain? _____ • Excessiveiy heavy No ( ) Yes ( ) • Heavy days (# tampons or pads) _____	Left or Right Breast (please circle one) • Discharge No ___ Yes ___ • Lump/s No ___ Yes ___ • Pain No ___ Yes ___ • Self-Exam No ___ Yes ___

FOR WOMEN WHO ARE MENOPAUSAL

Age at menopause _____ Hormone Replacement Therapy No _Yes ___ HRT medications:	Hot Flashes No ___ Yes ___ Insomnia No ___ Yes ___	Night Sweats No ___ Yes ___ Vaginal Dryness No ___ Yes ___

ADDITIONAL SYMPTOMS

Abnormal Bleeding	No ___ Yes ___	Sexual dysfunction	No ___ Yes ___
Anxiety	No ___ Yes ___	Sleep disturbances	No ___ Yes ___
Decreased desire for sex	No ___ Yes ___	Vaginal Itching	No ___ Yes ___
Depression	No ___ Yes ___	Vaginal discharge	No ___ Yes ___
Difficulty falling asleep	No ___ Yes ___	Waking to urinate	No ___ Yes ___ How many times? ___
History of infertility	No ___ Yes ___	Urinary incontinence	No ___ Yes ___
Abnormal Vaginal Discharge	No ___ Yes ___	Urinary urgency	No ___ Yes ___
Painful Intercourse	No ___ Yes ___		

MEDICATIONS REVIEW (be sure to include over the counter meds and supplements)

NAME (BRAND OR GENERIC)	DOSAGE	HOW OFTEN	START DATE	NAME OF PRESCRIBING DOCTOR

PHARMACY:

Name:	Address:

SINCE YOUR LAST ANNUAL EXAM:

Have you had any surgery? No ___ Yes ___ Had any new medical problems? No ___ Yes ___ Developed any new allergies? No ___ Yes___ Are there recent family member's illnesses we should know about? No ___ Yes ___	Type: Type: Type: If yes, please describe:

Have you had any major life changes this year (Health, Pregnancy, Family or Social) No ___ Yes ___

Please Explain:

Additional concerns: No ___ Yes ___

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NUTRITION: Calcium Supplements Yes ( ) No ( ) Years taken:

Vitamin D Supplements Yes ( ) No ( ) Years taken:

Multivitamin Supplements Yes ( ) No ( ) Years taken:

SOCIAL HISTORY: SINGLE ___ MARRIED ___ ENGAGED ___ DIVORCED ___ WIDOW ___

- Are you currently sexually active? YES___ NO___

With a: Man ___ Woman ___ Both ___

- How many sexual partners do you have? _____

EXERCISE: TYPE _____ FREQUENCY: _____

ALCOHOL USE: _____ FREQUENCY: _____

TOBACCO USE: CURRENT: No ___ Yes ___ FORMER: No ___ Yes ___ PACKS/PER DAY ___

RECREATIONAL DRUGS: CURRENT: No ___ Yes ___ TYPE: _____ FORMER: No ___ Yes ___

CAFFEINE USE: CURRENT: No ___ Yes ___ TYPE _____ AMOUNT DAILY: _____

HISTORY OF DOMESTIC VIOLENCE (CONFIDENTIAL):

ARE YOU A VICTIM OR SURVIVOR OF PHYSICAL OR SEXUAL ABUSE NO ( ) YES ( )

WHEN WAS YOUR LAST?

TEST HISTORY	DATE	NORMAL	ABNORMAL
LAST PAP TEST			
MAMMOGRAM			
OSTEOPOROSIS TEST (DEXA OR BONE DENSITY SCAN)			
COLONOSCOPY To be repeated in ____ years			

Do you want Sexually Transmitted Diseases testing (STDs)?	No ( ) Yes ( )
I request testing for: (please check): _____Gonorrhea _____ Chlamydia	*Chlamydia and Gonorrhea* are two of the most commonly transmitted STDs in the US. *Symptoms:* can include discharge, irregular bleeding, abnormal or pelvic pain, painful intercourse, vague bladder symptoms or they may be "silent" with no symptoms at all. *Testing:* a sample is taken from the cervix, similar to a PAP smear. *Cost:* ranges from $75- $125, depending on the lab your insurance requires us to use, and MAY or MAY NOT be covered by the insurance
I request testing for: (please check):_____Syphillis ____ Heptatitis B/C ____ HIV	• *Syphilis, Hepatitis B / C and HIV (Aids Virus)* can be tested with a blood sample. • Your insurance MAY or MAY NOT cover the test.
Please sign here to authorize this testing:	DATE:

GARDISIL VACCINE

If you are age 45 or LESS, have you received the Gardisil Vaccine for Human Papilloma Virus (HPV) to help prevent genital warts and cervical cancer? Yes ( ) No ( )

If you have not received the vaccine, are you interested in getting the vaccine at this time? Yes ( ) No ( )

Thank you for taking the time to share this information so we can be your partner in your health care.

PATIENT SIGNATURE _____ PROVIDER SIGNATURE _____

DATE: _____

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Hereditary Risk Assessment

Name: _____ Date of Birth: _____ Date: _____

Based on the information you provide here, you MAY be appropriate for genetic testing and your provider may be able to change your medical management to improve your care. Include the following blood relatives on both your mother's and father's side of the family: **parents, siblings, children, grandparents, grandchildren, aunts, uncles, nieces and nephews.**

Do you think you may become pregnant in the next 2 years? Yes No Maybe N/A

Have you had hereditary cancer genetic testing? Yes No Unsure

If YES, results were: ☐ Negative ☐ Positive, Gene:_____

➔ **IF YOU ANSWERED 'YES' AND HAVE ALREADY HAD MYRISK CANCER GENETIC TESTING, PLEASE STOP HERE** STOP

Have YOU ever been diagnosed with the following:			**Which Cancer:**	**Age of Diagnosis**
Breast, ovarian, pancreatic or colon/rectal cancer at any age	Yes	No		
Uterine/endometrial cancer before age 65	Yes	No		

Have your relatives ever been diagnosed with the following:			**Which Relative(s):** (Write 'M'=Maternal or 'P'=Paternal)	**Age of Diagnosis**
Breast cancer at age 49 or younger	Yes	No		
Ovarian cancer at any age	Yes	No		
Breast cancer in both breasts (bilateral) at any age	Yes	No		
3 breast cancers on the same side of the family at any age	Yes	No		
Male breast cancer at any age	Yes	No		
A first degree relative (parent, sibling or child) with colon or uterine cancer before age 50	Yes	No		
A first degree relative (parent, sibling or child) with pancreatic cancer OR metastatic prostate cancer at any age	Yes	No		
3 or more of the following cancers on the same side of the family at any age: uterine, colon, stomach	Yes	No		
Jewish ancestry with one or more breast cancer in the family	Yes	No		

Have any relatives been tested for genes that cause cancer? Yes No If yes, explain:_____

Patient Signature: _____ **Provider you are seeing today:** _____

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Patient is a candidate for genetic testing: **Yes** **No**

___ Patient accepted ___ Patient declined

___ Patient will confirm hx with relatives ___ Genetic testing information provided PROVIDER INITIALS: _____