Stanford HEALTH CARE

VALLEYCARE PHYSICIANS ASSOCIATES

Your name:_____ Date of Birth:____/____/_____ Today's Date:____/____/_____

Annual / Well Woman Gynecological Exam

First day of your last menstrual period_____ Have you had a hysterectomy? __ No __ Yes

Any problems with your period?_____How many days do they last?_____

Are you sexually active? __ No __ Yes Any problems with intercourse?_____

How many sexual partners have you had within the last year?_____

What is your current method of birth control: __ None __ Pill □ Patch □ Nuvaring □ IUD □ Condoms Other_____
Do you want to change your current method? ___No __Yes

Are you thinking of conceiving in the next year? __No __ Yes

When was your last Pap Smear _____ Mammogram (40+) _____

Colonoscopy (50+) _____ Dexa/Bone Scan (65+)_____

Do you smoke cigarettes? __ No __ Yes If yes,_____amt/day for how long?_____

Do you drink alcohol? __No __ Yes If yes, _____amt □day □week □month

Have you been a victim of abuse or domestic abuse? __No __ Yes

How many times have you been pregnant?_____ How many children do you have?_____

How many were _____vaginal _____cesarean sections _____miscarriages _____abortions

Any new medical condition/problems within the last year? __ No __ Yes ***(please list below)***

Condition/Problem	Treatment/Hospitalization

Condition/Problem	Treatment/Hospitalization

Any new family history of

☐ Breast cancer Relationship_____
☐ Colon cancer Relationship_____
☐ Diabetes Relationship_____
☐ Heart disease Relationship_____
☐ High blood pressure Relationship_____
☐ Ovarian cancer Relationship_____
☐ Thyroid disease Relationship_____
☐ Other: Relationship_____

Please list any prescribed medications you are currently taking: ☐ **None**

Name	Dose

Name	Dose

Preferred Pharmacy ☐Mail Order

Name _____ Address _____ City _____

Any concerns you would like to discuss today:_____

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