Stanford HEALTH CARE
STANFORD MEDICINE

UNIVERSITY HEALTHCARE ALLIANCE

Your Name:_____Date of Birth:___/_____/_____ Today's Date:____/____/____

The following questions cover important gynecologic issues for all women. We strongly encourage everyone to have a primary care physician or internist to cover other health issues.

Annual / Well Woman Preventative Exam

Date of last menstrual period:_____ □ None due to □ Hysterectomy □ Menopausal
How many days do they last?_____ Any problems with your period?_____
Are you sexually active? □ No □Yes Any problems with intercourse?_____
How many sexual partners have you had within the last year?_____ (partner gender) □ Male □ Female

What is your current method of birth control: _____
Do you want to change your current method? □No □Yes
Are you thinking of conceiving in the next year? □ No □ Yes

Do you smoke? □ No □ Yes □Never smoked □ Quit Do you use smokeless tobacco? □ No □ Yes
Do you drink alcohol? □ No □ Yes If yes, _____drinks per □day □week □month

Have you been pregnant or delivered a child since your last visit with us? □ No □ Yes
Have you been a victim of abuse or domestic abuse? □ No □ Yes

Within the last year: □ None
Any new diagnosed medical conditions:_____
Had any surgery performed:_____

Any new family history of □ None
□Breast cancer Relationship/Age of onset_____
□Colon cancer Relationship/Age of onset_____
□Ovarian cancer Relationship/Age of onset_____
□Other: Relationship/Age of onset_____

Current Medications (if refill desired, check box)

Refill	Name and Dose	How are you taking it?
□		
□		
□		
□		

Preferred Pharmacy ☐Mail Order Name: _____ City: _____

Your insurance's preferred laboratory for testing (if known): _____

Please complete back page

When was your last:

Pap smear (25y+) :_____ was HPV co-testing ordered? □Yes □No □Unsure

Mammogram (40y+):_____ Do you need an order today? □ Yes □No

Where was your last one performed: □ ValleyCare □ Norcal □ Other:_____

Colonscopy (50y+) _____

Dexa/Bone Scan (65y+) _____

The American College of Obstetrics and Gynecology (ACOG) recommends Sexually Transmitted Infections testing on sexually active women.

Would you like any of the following testing ordered or performed today*? □ No □ Yes

If yes, Please Circle: HPV Chlamydia Gonorrhea Genital Herpes HIV Syphilis Hepatitis B

*deductible or copay may apply to the laboratory performing the test.

Circle any of the following that you are currently experiencing □ NONE

General:	Extreme Fatigue	Depression	Fatigue	
	Weight change in the last year? How much?_____		Gain or loss?_____	
	Heat intolerance	Cold intolerance		
Skin:	Change in mole	Rash		
Respiratory/Cardiac:	Shortness of breath	cough	Chest pain	palpitations
Breast:	Lump	Nipple discharge	Redness	
Gastrointestinal:	Abdominal pain	Black or bloody stools	Bloating	Diarrhea
	Change in bowel movements	Constipation	Nausea	Vomiting
Gynecologic:	Abnormal vaginal bleeding	Pain with bleeding	Pain with intercourse	
	PMS symptoms _____			
	Menopausal symptoms _____			
Urinary:	Loss of urine	Blood in urine	Urinary frequency	urgency
	Pain with urination			
Musculoskeletal:	Muscle aches	Muscle weakness		
Neurological:	Change in headaches	Numbness	dizziness	

----------For Clinic Use Below----------

Weight _____

Blood Pressure _____/_____

MD to order □ Pap Smear □ Mammogram □ HPV □ Other □ STI