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 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? □Never smoked □ Quit □ Yes Type: □ Cigarettes □ E-cigarettes For how long:_____
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: _____

Please complete back page

University HealthCare Alliance ("UHA") is a medical foundation affiliated with Stanford Health Care and Stanford Medicine. UHA contracts with a number of physician groups to provide the medical care in the UHA clinics. Neither UHA, Stanford Health Care, nor Stanford University employ the physicians in the clinics and do not exercise control over the professional services provided by the physician groups.
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Your Name:_____Date of Birth:___/_____/_____ Today's Date:____/____/____

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 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 _____/_____

Orders: □ Pap Smear □ Mammogram □ HPV □ Other □ STI