Women's Specialists of New Mexico, Ltd.

Follow Up Annual Exam Update

(505) 843-6168 www.wsnm.org

Updated 02/03/11

Name:	Age:	Birth Date:	Today's Date:

Primary Care Provider:	Do you have advanced directives? ☐ Yes ☐ No	Would you like a chaperone for your exam today? ☐ Yes ☐ No

Please describe any special problems or symptoms that you would like to discuss.

PREVENTIVE HEALTH

	Date of last:		Date of last:		Date of last:
Pap		Dental Exam		Bone Density	
Mammogram		Eye Exam		Breast Cancer Gene	☐ Yes ☐ No
Blood Work		Colonoscopy		Other:	

MEDICAL HISTORY

Please check any past or current medical problems for yourself or immediate, blood relative.

Grandparents:

X = Yourself M = Mother F = Father S = Sister B = Brother Maternal = MGM or MGF Paternal = PGM or PGF

	You	Family		You	Family
Blood Clots in legs or lungs			High Blood Pressure		
Cancer Breast			Mental Illness, Depression		
Cancer Colon			Osteoporosis		
Cancer Ovarian			Stroke		
Diabetes			Thyroid Disease		
Heart Disease			Other:		

SURGERIES

☐ Yes ☐ No Have you ever been hospitalized, had surgery, been injured or been pregnant since your last visit? Please list:

Date: Reason:

☐ Yes ☐ No Have you been diagnosed with any new medical conditions since your last visit? Diagnosis:

SOCIAL HISTORY

Marital Status: ☐ Divorced ☐ Engaged ☐ Married ☐ Partnered ☐ Separated ☐ Single ☐ Widowed

Patient Occupation:	Husband / Partner's Occupation:
Number of children living at home:	Do you use recreational drugs? ☐ Yes ☐ No
Are you currently smoking? ☐ Yes ☐ No	Is your diet nutritionally balanced? ☐ Yes ☐ No
Do you drink alcohol? ☐ Yes ☐ No	Do you exercise? ☐ Yes ☐ No If yes, # of times per week:

CURRENT MEDICATION

List any MEDICATIONS you are taking, to include birth control pills, Tylenol, Advil, Aspirin, other non-prescription medicine, vitamins, herbs.

Medication Name	Dose	Frequency of Dose	Medication Name	Dose	Frequency of Dose

Do you take Calcium?	☐ Yes ☐ No	If yes, amount:
Do you take Vitamin D?	☐ Yes ☐ No	If yes, amount:
Do you take Multi Vitamins or Prenatal Vitamins?	☐ Yes ☐ No	

Name:	DOB:	Date:

MEDICATION ALLERGIES

Do you have any medication allergies? ☐ Yes ☐ No	If yes, to what?	What type of reaction do you have?

FOOD ALLERGIES

Do you have any food allergies? ☐ Yes ☐ No	If yes, to what?	What type of reaction do you have?

ENVIRONMENTAL / LATEX ALLERGIES

Do you have any environmental / latex allergies? ☐ Yes ☐ No	If yes, to what?	What type of reaction do you have?

MENSTRUAL HISTORY

First day of last normal menstrual period - Date:	Is menstrual pain or cramping a problem for you? ☐ Yes ☐ No
Number of days between periods:	Do you ever have spotting or bleeding in between your periods: ☐ Yes ☐ No
Length of periods (# of days of bleeding):	
Menstrual flow: ☐ Light ☐ Medium ☐ Heavy	Is PMS a problem for you? ☐ Yes ☐ No
	Do you perform self breast exams? ☐ Yes ☐ No

How often do you change pads / tampons on your heaviest day of menses? Every ___________ hours

Current Method of Birth Control:

☐ Condoms	☐ Hysterectomy	☐ Foam, Jelly, etx.	☐ Vasectomy
☐ Contraceptive Pills	☐ Implanon	☐ Patch	☐ Other:
☐ Depo Provera	☐ IUD	☐ Post Menopause	☐ None
☐ Diaphragm	☐ Not Sexually Active	☐ Same Sex Partner	
☐ Essure	☐ Nuva Ring	☐ Tubal Ligation	

Are you interested in a different method of birth control? ☐ Yes ☐ No

GYN HISTORY

☐ Yes ☐ No Have you had a new sexual partner since your last visit?

☐ Yes ☐ No Do you have pain with intercourse?

☐ Yes ☐ No Do you have bleeding with or after intercourse?

☐ Yes ☐ No Do you have any concerns about sexual relations?

☐ Yes ☐ No Have you been diagnosed with a female infection since your last visit?

If yes please indicate:

☐ Chlamydia	☐ Chronic Yeast Infection
☐ Gonorrhea	☐ Bacterial Vaginosis
☐ Syphilis	☐ Vaginal Herpes
☐ Trichomonas	☐ Vaginal Warts / HPV

☐ Yes ☐ No Would you like to be tested for Sexually Transmitted Infections?

☐ Yes ☐ No Do you have problems with bladder or bowel control?

☐ Yes ☐ No Do you have any of the following menopause or perimenopause symptoms?

☐ Hot Flashes	☐ Night Sweats
☐ Vaginal Dryness	☐ Difficulty Sleeping

☐ Yes ☐ No Have you had a recent major stress?

☐ Loss of job	☐ Change in marital status
☐ Loss of loved one	☐ Other:

☐ Yes ☐ No Within the past year have you been ☐ physically abused or ☐ emotionally abused?

☐ Yes ☐ No Is this something you would like to discuss today?

☐ Yes ☐ No Do you feel safe in your home?

VERIFICATION

Patient Signature:	Patient's ID Number:
Physician Signature:	Date:

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