

Wellesley Women's Care

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Annual Gynecological Update

Since your last visit: Present Marital Status: S M D W SEP Have you had any test? Mammogram, x-rays, CT scan, MRI, lab work etc. Yes. / No Have you been hospitalized or had any surgery? If yes, specify: Yes. / No Have you been hospitalized or had any surgery? If yes, specify: Yes. / No Have you started any new medications, prescription and nonprescription, including HRT, vitamins, supplements? Yes. / No Have you developed new allergies? If yes, specify: Yes. / No Have you daving any marital or sexual concerns? If yes, please specify Yes. / No Have you currently using birth control OR have you used emergency contraception? Yes. / No If yes, please specify Yes. / No No Have you currently wing birth control OR have you used emergency contraception? Yes. / No If yes, please specify Yes. / No No Are you currently wing to conceive? If yes, how non how hong have you been trying? Yes. / No If yes, please specify Yes. / No No Yes. / No If yes, please specify Yes. / No Yes. / No	Name:	DOB:Todays Date:					
If yes, specify: Yes / No Have you been hospitalized or had any surgery? If yes, specify: Yes / No Have there been any illnesses or deaths in your family? If yes, specify: Yes / No Have you started any new medications, prescription and nonprescription, including HRT, vitamins, supplements? Yes / No Have you developed new allergies? If yes, specify: Yes / No Are you having any marital or sexual concerns? If yes, please specify Yes / No Has there been any change in the frequency of your sexual activity or sexual partner? Yes / No If yes, please specify Yes / No Have you been exposed to any sexually transmitted diseases? If yes, please specify Yes / No If yes, please specify Yes / No If yes, please specify Yes / No Have you been exposed to any sexually transmitted diseases? If yes, please specify Yes / No If yes, please specify Yes / No If yes please specify Yes / No If yeu are currently NOT using birth control OR have you used emergency contraception? Yes / No If yeu are currently NOT using birth control and are sexually active, please indicate how long? Yes / No Exercise Sedentary If yes, how long have you been trying? Yes / No If you	Since your	last visit: Present Marital Status: S	MD	V	V SEP		
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Do you wear seatbelts ? Yes / No	Personal / P		_				
		Is Domestic Violence a concern for you ?	Yes	/	No		
Do you do self breast exams ? Yes / No		Do you wear seatbelts ?	Yes	/	No		
		Do you do self breast exams ?	Yes	1	No		

Date of last menstrual period:	Period every days	(28-30)	How many days do you normally flow ? (3-5, 5-7)
Is your flow Light Average Heavy)			
Do you experience irregularity, spotting, pain,	or discharge?	Yes / No	
Do you experience any clots, cramping?		Yes / No	

If you have had any changes in your medical status, please indicate below:

Weight loss/gain	Bladder/urinary problems	Breast Discharge
Changes in appetite	Vaginal Infection/discharge	Menstrual Cycle Changes
Abdominal pain	Bowel problems/pain	Menopausal Symptoms

Anything more, you would like us to know: