

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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| Is Domestic Violence a concern for you ? Yes / No Do you wear seatbelts ? Yes / No | Drugs | | Yes | / | No | | |
| 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: