WWC OB-GYN
Wellesley Women's Care

## Wellesley Women's Care — Annual Gynecological Update

**Name: _____DOB:_____Todays Date:_____**

**Since your last visit:** **Present Marital Status: S M D W SEP**

| | |
|---|---|
| Have you had any tests? Mammogram, x-rays, CT scan, MRI, lab work etc. 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? If yes, specify: | 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? If yes, please specify | Yes / No |
| Have you been exposed to any sexually transmitted diseases? If yes, please specify | Yes / No |
| Are you currently using birth control **OR** have you used emergency contraception? If yes, please specify | Yes / No |
| If you are currently NOT using birth control and are sexually active, please indicate how long? | Yes / No |
| Are you currently trying to conceive? If yes, how long have you been trying? | Yes / No |
| **Exercise** ☐ Sedentary ☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf) ☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.) ☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes) | |
| **Diet** Are you dieting? If yes, are you on a physician prescribed medical diet? Yes / No | Yes / No |
| **Caffeine** ☐ **Coffee** ☐ **Tea** ☐ **Cola** **# of cups/cans per day?** | Yes / No |
| **Alcohol** Do you drink alcohol? If yes, what kind? How many drinks per week? Are you concerned about the amount you drink? Yes / No | Yes / No |
| **Tobacco** Do you use tobacco? ☐ Cigarettes – pks./day ☐ # of years ☐ Or year quit | Yes / No |
| **Drugs** Do you currently use recreational or street drugs? Have you ever given yourself street drugs with a needle? Yes / No | Yes / No |
| **Personal / Preventative Health safety** | |
| Is Domestic Violence a concern for you ? | Yes / No |
| Do you wear seatbelts ? | Yes / No |
| Do you do self breast exams ? | Yes / 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: