Annual Exam Questionnaire

Name:______________________________ DOB: ___/___/_____

Are you allergic to any medications?____

Present Medication you are taking: ____

When was the first day of your last menstrual cycle? ___/___/_____

Have you stopped having menstrual cycles? **YES NO**

If yes, Why? Please circle one: Hysterectomy Menopause Ablation Continuous Birth Control Depo Provera

Circle your current Birth Control: None IUD Condoms Tubal Ligation Essure Nuva Ring Husband Vasectomy
Birth Control Pills __________________ Other _________________________

Do you wish to change your method of birth control ? **YES NO**

YES NO

___ ___ Have you ever had an abnormal pap?

___ ___ Do you practice self breast exam?

___ ___ Is your mammogram current? Date ___/___/_____

___ ___ Do you drink alcohol?

___ ___ Do you smoke?

Do Your Periods:

* Last longer or seem heavier? Y N
* Affect your daily activity? Y N
* Require extra protection? Y N
* Prior to Birth Control Pills heavy at anytime? Y N

Do you have any questions for concerns you would like to address to the doctor?

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Would you like to have any labwork done today? **YES NO Please read carefully**! We do not check benefits for labs, and not all insurance companies cover yearly lab work and you may receive a bill. Also, labs are most accurate if you are fasting.

Pharmacy Information:
Name ______________________________
Phone: ______________________________
Address (cross streets) ______________________________

Contact Information: Circle preferred
Home: ______________________________
Work: ______________________________
Cell: ______________________________