**NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ AGE \_\_\_\_\_\_\_\_\_**

**DO YOU HAVE PREVENTATIVE CARE WITH YOUR INSURANCE?** **YES OR NO**

WHEN WAS YOUR LAST PHYSICAL? \_\_\_\_\_\_\_\_\_\_\_\_\_ WHEN WAS YOUR LAST MAMMOGRAM? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

WHEN WAS YOUR LAST PERIOD? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ WHEN WAS YOUR LAST PAP? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

WHEN WAS YOUR LAST TETANUS? \_\_\_\_\_\_\_\_\_\_\_\_\_ WHEN WAS YOUR LAST COLONOSCOPY? \_\_\_\_\_\_\_\_\_\_\_\_\_

HAVE YOU EVER HAD AN ABNORMAL PAP? YES NO DO YOU SMOKE? YES NO

DO YOU HAVE ANY VAGINAL DISCHARGE? YES NO ARE YOU SEXUALLY ACTIVE? YES NO

**IF YOU HAVE BEEN PREGNANT PLEASE INDICATE HOW MANY:**

PREGNANCIES\_\_\_\_ ABORTIONS/MISCARRIAGES\_\_\_\_ LIVING CHILDREN\_\_\_\_ FULL TERM BIRTHS\_\_\_\_ PREMATURE BIRTHS\_\_\_

HAVE YOU EVER HAD A SEXUALLY TRANSMITTED DISEASE? YES NO

DO YOU HAVE HOT FLASHES? YES NO ARE YOU ON HORMONE REPLACEMENT? YES NO

HOW OFTEN DO YOU PERFORM SELF BREAST EXAMS? LESS OFTEN THAN MONTHLY\_\_\_\_\_\_ MONTHLY \_\_\_\_\_\_

DO YOU HAVE A HISTORY OF BREAST PROBLEMS? YES NO

**IS THERE A FAMILY HISTORY OF:**

BREAST CANCER YES NO COLON CANCER YES NO UTERINE CANCER YES NO OVARIAN CANCER YES NO OSTEOPOROSIS YES NO HEART DISEASE YES NO

OVER THE LAST 2 WEEKS HAVE YOU EVER FELT DOWN, DEPRESSED OR HOPELESS? YES NO

OVER THE LAST 2 WEEKS HAVE YOU FELT LITTLE INTEREST OR PLEASURE DOING THINGS? YES NO

***UNDER 50 YEARS OLD, PLEASE COMPLETE REST OF FORM***

HOW OFTEN DO YOU USUALLY GET YOUR PERIOD? EVERY \_\_\_\_\_\_\_\_ DAYS

ARE YOUR PERIODS USUALLY NORMAL? YES NO HOW MANY DAYS DO THEY USUALLY LAST? \_\_\_\_\_\_\_\_ DAYS

THE BLOOD FLOW IS USUALLY: LIGHT\_\_\_\_\_\_ MODERATE\_\_\_\_\_\_ HEAVY\_\_\_\_\_\_

DO YOU HAVE ANY BLEEDING IN BETWEEN PERIODS? YES NO

DO YOU AND YOUR PARTNER USE BIRTHCONTROL? YES NO METHOD: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**for physician use:**

Imunizations Preventative

Tdap Pneumovax Influenza Colonoscopy EKG Bone Density Stress Test



 Mammo Pap CT Lung Screen AAA Screen

labs Studies

CBC CMP Lipid Glucose TSH Chest X-Ray Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_