SWEDISH MEDICAL GROUP

ESTABLISHED PATIENT ANNUAL EXAM FORM

Today's Date: _____Name:_____ Date of Birth: _____ Age: _____
Occupation:_____Partner's Name:_____ Partner's Gender: _____
Non-OB/GYN Primary Doctor:_____
Medical Allergies/Reactions:_____
_____
Current Medications/Dose (including over the counter medications and supplements): _____
_____
_____

List any concerns you would like to discuss today: _____
_____
List any changes in health since your last annual exam:_____
_____
List any surgeries since your last annual exam: _____
_____
List any changes in family history since your last annual exam: _____
_____

Menstrual History:
Are you having periods? ☐ Y ☐ N (If no, skip to *)
First day of last period: _____
Are your periods monthly? ☐ Y ☐ N
How many days do you bleed?_____
How many days is your cycle (from start of period to start of the next period)?_____
On your heaviest days, how often do you change your pad/tampon? _____
Do you have irregular periods? ☐ Y ☐ N
List any problems with your periods: _____

*If you are through menopause, have you had any bleeding at all? ☐ Y ☐ No
*If menopausal, at what age did your periods stop? ____

Sexual history:
Are you sexually active? ☐ Y ☐ N Sexual preference: ☐ men ☐ women ☐ both
Any new partners in the last year? ☐ Y ☐ No
How long with current partner:_____Birth Control Method:_____
Do you want to be tested for STDs? ☐ Y ☐ No

Date of most recent: Pap: _____ HPV Vaccine: _____Tdap: _____
Mammogram:_____ Colonoscopy: _____Blood work:_____ Bone density: _____

Health Habits
Do you use tobacco? ☐ Y ☐ N Circle: Smoke, Vape, Chew
Amount per day:_____How Long:_____
Are you planning to or when did you quit?_____
Alcohol: Drinks per week:_____Quit:_____
Drug use: _____Quit:_____
Do you have any objections to blood transfusion? ☐ Y ☐ N
Caffeine per day:_____
What is your exercise regimen? _____
How would you describe your diet?_____
If you bike, do you use a helmet? ☐ Y ☐ N
Do you use a seat belt? ☐ Y ☐ N
How often do you perform breast self-exams? _____
What is your daily calcium intake (diet and/or supplements)? _____
What is your daily Vitamin D intake? _____
Do you have any history of sexual abuse? ☐ Y ☐ N
Do you feel safe at home/work? ☐ Y ☐ N