

Harmony Women's Health

Annual Office Visit

Name: _____ Age: _____ Date: _____

What issues would you like addressed today? _____

What is the date (month & year) of your most recent:

	Date	Result
Pap smear		
Mammogram		
Bone density		
Colonoscopy		

Do you know how to do self breast exams? Yes No
Do you do them each month? Yes No

What was the date of your last menstrual period?	
What is the usual number of days in your menstrual cycle from the beginning of one period to the beginning of the next?	
How many days of flow?	
How many days of spotting?	
Are your periods predictable?	

What is your current method of birth control:

- | | | |
|--|--|--|
| <input type="checkbox"/> Nothing-trying to conceive | <input type="checkbox"/> Condoms | <input type="checkbox"/> Tubal ligation |
| <input type="checkbox"/> Nothing-taking chances | <input type="checkbox"/> Patch or ring | <input type="checkbox"/> Diaphragm |
| <input type="checkbox"/> Nothing-not sexually active | <input type="checkbox"/> Pill | <input type="checkbox"/> Cervical cap |
| <input type="checkbox"/> IUD | <input type="checkbox"/> Rhythm | <input type="checkbox"/> Hysterectomy |
| | <input type="checkbox"/> Withdrawal | <input type="checkbox"/> Post-menopausal |
| | <input type="checkbox"/> Vasectomy | <input type="checkbox"/> Other _____ |

What medications are you taking on a regular basis? Include antidepressants, birth control pills, blood pressure medications, vitamins, sleeping pills, Tylenol, Motrin, herbs, etc. _____

What health problems are you currently being treated for? _____

How do you get exercise?

- | | |
|--|---|
| <input type="checkbox"/> Couch potato | <input type="checkbox"/> Many athletic activities |
| <input type="checkbox"/> Running after the kids | <input type="checkbox"/> Elite athlete |
| <input type="checkbox"/> Physically demanding job | <input type="checkbox"/> Limited exercise due to health |
| <input type="checkbox"/> Health club-use regularly | <input type="checkbox"/> Can't exercise at all |
| <input type="checkbox"/> Weekend warrior | <input type="checkbox"/> Housebound |

What is your current work status?

- | | |
|---|--|
| <input type="checkbox"/> Employed full time, but regularly work more than 40 hours per week | <input type="checkbox"/> Laid off recently |
| <input type="checkbox"/> Employed full time, 40 hours per week | <input type="checkbox"/> Taking time off from the rat race |
| <input type="checkbox"/> Employed part time | <input type="checkbox"/> Full time student |
| <input type="checkbox"/> Unemployed-looking for work | <input type="checkbox"/> Part time student |
| <input type="checkbox"/> Unemployed-have given up finding work | <input type="checkbox"/> Full time mom |
| | <input type="checkbox"/> Full time homemaker |
| | <input type="checkbox"/> Retired |
| | <input type="checkbox"/> Disabled |

How many hours do you allow for sleep? _____

How much sleep do you get a night? _____

What is your diet like? Check all that apply

- | | |
|---|--|
| <input type="checkbox"/> Carb cravings | <input type="checkbox"/> Mediterranean |
| <input type="checkbox"/> Sweet tooth | <input type="checkbox"/> Vegetarian |
| <input type="checkbox"/> Junk food | <input type="checkbox"/> Vegan |
| <input type="checkbox"/> Atkins/South Beach | <input type="checkbox"/> Macrobiotic |
| <input type="checkbox"/> Weight watchers | <input type="checkbox"/> Anti-candida diet |
| <input type="checkbox"/> Sugar busters | |

How many cups (8 ounces) of caffeinated beverages do you drink per day? Include coffee, tea, and soda.

- | | |
|--|-----------------------------------|
| <input type="checkbox"/> None, everything is decaffeinated | <input type="checkbox"/> 2-4 cups |
| <input type="checkbox"/> 1-2 cups | <input type="checkbox"/> 4-6 cups |
| | <input type="checkbox"/> >6 cups |

How many cigarettes do you smoke per day? _____ **For how long?** _____

How many alcoholic drinks do you have per week? _____ Do you, your family or friends criticize the amount you drink? _____ Do you feel guilty about the amount you drink? _____ Do you drink in the morning? _____ Do you drink to stop the pain? _____

What is your current marital status?

- | | | |
|---|--------------------------------------|-----------------------------------|
| <input type="checkbox"/> Single | <input type="checkbox"/> Married | <input type="checkbox"/> Divorced |
| <input type="checkbox"/> Committed relationship | <input type="checkbox"/> Civil union | <input type="checkbox"/> Widowed |
| | <input type="checkbox"/> Separated | |

Are you in a relationship with someone who has ever physically hurt or threatened you? _____ When you disagree at home, are you ever afraid of what your partner might do to you, your children, or your possessions? _____ Does your partner ever try to control what you do, where you go, your money, or relationships with your family and friends? _____ Does your partner ever force you to engage in unwanted sex or sex that makes you feel uncomfortable? _____

Review of systems: For each of the symptoms listed below, please indicate your worst level of interference with your life over the last month using a 0 to 10 scale, where 0 is no interference with your life and 10 is the worst imaginable.

	0	1	2	3	4	5	6	7	8	9	10
Pelvic pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Level of cramps with period	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Deep pain with intercourse	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Burning vaginal pain with sex	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Vulvar pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Vaginal itching	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Vaginal discharge	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Heavy bleeding with periods	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Irregular periods	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bleeding between periods	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lack of interest in sex	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Infertility	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
PMS symptoms	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hot flashes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Allergies	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Eczema	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Backache	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bloating	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Muscle/joint pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Fatigue/exhaustion	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	0	1	2	3	4	5	6	7	8	9	10
Night sweats	0	0	0	0	0	0	0	0	0	0	0
Craving sweets, bread or pasta	0	0	0	0	0	0	0	0	0	0	0
Difficulty concentrating	0	0	0	0	0	0	0	0	0	0	0
Low grade fevers	0	0	0	0	0	0	0	0	0	0	0
Swollen glands	0	0	0	0	0	0	0	0	0	0	0
Migraine headache	0	0	0	0	0	0	0	0	0	0	0
Control over your weight	0	0	0	0	0	0	0	0	0	0	0
Depression	0	0	0	0	0	0	0	0	0	0	0
Anxiety	0	0	0	0	0	0	0	0	0	0	0
Irritability	0	0	0	0	0	0	0	0	0	0	0
Stress	0	0	0	0	0	0	0	0	0	0	0
Sleep problems	0	0	0	0	0	0	0	0	0	0	0
Digestive problems	0	0	0	0	0	0	0	0	0	0	0
Heartburn	0	0	0	0	0	0	0	0	0	0	0
Constipation	0	0	0	0	0	0	0	0	0	0	0
Diarrhea	0	0	0	0	0	0	0	0	0	0	0
Bloating	0	0	0	0	0	0	0	0	0	0	0
Getting up at night to urinate	0	0	0	0	0	0	0	0	0	0	0
Frequent urination	0	0	0	0	0	0	0	0	0	0	0
Need to urinate with little warning	0	0	0	0	0	0	0	0	0	0	0
Frequent bladder infections	0	0	0	0	0	0	0	0	0	0	0
Abnormal thirst	0	0	0	0	0	0	0	0	0	0	0
Hair loss	0	0	0	0	0	0	0	0	0	0	0
Shortness of breath	0	0	0	0	0	0	0	0	0	0	0
Dizziness	0	0	0	0	0	0	0	0	0	0	0
Heart palpitations	0	0	0	0	0	0	0	0	0	0	0
Swelling of the legs	0	0	0	0	0	0	0	0	0	0	0
Chest pain	0	0	0	0	0	0	0	0	0	0	0

Is there anything you want to add that we have not asked? _____

Physical Examination:

Height: _____ Weight: _____ BMI _____ BP _____

	NL	Abn	
General appearance			
Neuro-psych			Depressed/anxious/agitated/weepy
Skin			
Neck			
Thyroid			
Respiratory effort			
Lungs			
Heart			
Peripheral vascular			
Breasts			
Abdomen (general)			
Liver/spleen			
Hernia			
Lymphatic			
Back			
EGBUS			
Urethra			
Bladder			
Vagina			
Pelvic support			
Cervix			
Uterus			
Adnexae			
Anus			
Rectum			
Stool guaiac			

Comments:
