Annual Well Woman Exam **Name**_____ **Date**_____

Age of Menarche _____
Last Menstrual Cycle _____ Menopause _____ Menstrual Interval (days between cycle) _____
Menstrual Flow _____ Painful Menstrual Cycles: Yes ☐ No ☐
Last Pap _____ Abnormal Pap _____ Colposcopy _____

Sexually Active: Yes ☐ No ☐
Pain with Intercourse: Yes ☐ No ☐
Number of Partners _____
STD Exposure: Gonorrhea _____ Chlamydia _____Trichomonas _____ HSV _____

Obstetrical History: Pregnancies____ Miscarriages ____ Abortions____ Living_____
Birth Control: _____
Hormone Replacement Therapy: _____

Surgery:
Hysterectomy _____ Oophorectomy (removal ovary) _____ Laparoscopic _____
Myomectomy (removal fibroid) _____ Ablation _____ D&C _____

Self-Breast Exam: Yes ☐ No ☐
Mammogram _____ Colonoscopy _____ Dexa Scan _____

Family History of Cancer
Breast Cancer _____ Cervical Cancer _____ Uterine Cancer _____
Colon Cancer _____Ovarian Cancer _____