

**ANNUAL EXAM**

Date: \_\_\_/\_\_\_/\_\_\_

Name: \_\_\_\_\_

DOB \_\_\_/\_\_\_/\_\_\_ Age \_\_\_ GR \_\_\_ p \_\_\_ LMP \_\_\_/\_\_\_/\_\_\_ Last Pap \_\_\_/\_\_\_/\_\_\_

Temp \_\_\_ BP \_\_\_ Wt \_\_\_ Ht \_\_\_ BMI \_\_\_ Pap Result: \_\_\_\_\_

Chief complaint: \_\_\_\_\_ Smoking status: \_\_\_\_\_  
 \_\_\_\_\_ Alcohol intake: \_\_\_\_\_

Contraception: \_\_\_\_\_ Recreational Drugs \_\_\_\_\_  
 Screening History: \_\_\_\_\_ Current Meds: \_\_\_\_\_

Last Mammogram: \_\_\_\_\_  
 Last Colonoscopy: \_\_\_\_\_  
 Last Bone Density: \_\_\_\_\_  
 Allergies: \_\_\_\_\_

Last Blood Work: \_\_\_\_\_  
 Supplements: \_\_\_\_\_  
 Immunization: Flu Pneumovax Gardasil Hepatitis \_\_\_\_\_

**Gynecologic History:**

Age at first menses: \_\_\_\_\_

Cycle: Regular? Y / N Painful? Y / N  
 How often? \_\_\_\_\_ # days it lasts \_\_\_\_\_

Flow? (circle one) light moderate heavy

Abnormal pap smears? Y / N Circle if appropriate:  
 Colposcopy Cryotherapy LEEP Cone

History of STD's? (circle) HPV Chlamydia Gonorrhea Herpes

**Past Obstetric History:**

Uncomplicated spontaneous vaginal deliveries? Y / N  
 Cesarean section? Y / N Any complications? Y / N  
 Weight of largest baby? \_\_\_\_\_

**What surgeries have you had in the past?**

|       |                     |       |                   |
|-------|---------------------|-------|-------------------|
| _____ | Cesarean section    | _____ | Joint replacement |
| _____ | Tubal Ligation      | _____ | Plastic           |
| _____ | Hysterectomy        | _____ | Oral surgery      |
| _____ | Laparoscopy         | _____ | Breast biopsy     |
| _____ | Abdominal surgery   | _____ | Mastectomy        |
| _____ | Heart Catherization | _____ | Hernia surgery    |
| _____ | Gall bladder        | _____ | Heart surgery     |
| _____ | Back surgery        | _____ | Tonsillectomy     |

Other surgeries \_\_\_\_\_

**What significant medical conditions do you have?**

|       |       |                  |
|-------|-------|------------------|
| _____ | H     | der              |
| _____ | e     | Stroke           |
| _____ | a     | Eye problems     |
| _____ | d     | Thyroid problems |
| _____ | a     | Diverticulitis   |
| _____ | c     | Depression Heart |
| _____ | h     | attack           |
| _____ | e     | Heart disease    |
| _____ | s     | Tuberculosis     |
| _____ | Seiz  | Asthma           |
| _____ | ure   | Emphysema        |
| _____ | disor | Kidney stones    |

**Family Medical History:**

|                 |     |               |                      |
|-----------------|-----|---------------|----------------------|
| Heart disease?  | Y/N | relationship: | _____                |
| Anxiet          | ___ | _____         | Cancer (any)         |
| y               | -   | _____         | Kidney disease       |
| <b>Social</b>   | ___ | _____         | Osteoporosis         |
| <b>History:</b> | -   | _____         | Bipolar disease      |
|                 | ___ | Other:        | High blood pressure  |
|                 | -   |               | Diabetes             |
|                 | ___ |               | Hypercholesterolemia |
|                 | -   |               | Arthritis            |
|                 | ___ |               | Endometriosis        |
|                 | -   |               | Blood clot (DVT)     |
|                 | ___ |               | Ulcer                |
|                 | -   |               | Liver disease        |

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cancer

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Breast cancer?

Ovarian cancer?

Colon cancer?

Osteoporosis?

Other?

**Comments:**

Y/N

Y/N

Y/N

Y/N

Y/N

Y/N

relationship:

relationship:

relationship:

relationship:

relationship:

relationship:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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04/24/11

ANNUAL EXAM (page two)

Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Reason for visit: \_\_\_\_\_

**Constitutional**

|   |  |
|---|--|
| <input type="checkbox"/> Well developed | <input type="checkbox"/> Other _____           |
| <input type="checkbox"/> Well nourished | <input type="checkbox"/> Other _____           |
| <input type="checkbox"/> Habitus        | <input type="checkbox"/> Obese [ ] Other _____ |
| <input type="checkbox"/> No deformities | <input type="checkbox"/> Other _____           |
|   | <input type="checkbox"/> Other _____           |

**Respiratory**

|                    |                                 |   |
|--------------------|---------------------------------|---|
| Respiratory Effort | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal _____ |
| Lungs              | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal _____ |

**Cardiovascular**

|                     |                                 |   |
|---------------------|---------------------------------|---|
| Heart               | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal _____ |
| Sounds              | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal _____ |
| Murmurs             | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal _____ |
| Peripheral/Vascular | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal _____ |

**Gastrointestinal**

|         |                                 |  |
|---------|---------------------------------|--|
| Abdomen | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal _____        |
| Hernia  | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal _____ Liver  |
|         | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal _____ Spleen |
|         | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal _____        |
| FOB     | <input type="checkbox"/> Done   | <input type="checkbox"/> Not Done _____        |

**Lymphatic**

|            |                                 |   |
|------------|---------------------------------|---|
| Neck       | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal _____       |
| Thyroid    | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal _____ Groin |
|            | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal _____       |
| Other Site | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal _____       |

**Skin**

|                 |                                 |   |
|-----------------|---------------------------------|---|
| Inspect/Palpate | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal _____ |
|-----------------|---------------------------------|---|

**Neurological/Psychological**

|                 |                                 |               |                                  |                              |
|-----------------|---------------------------------|---------------|----------------------------------|------------------------------|
| Orientation     | <input type="checkbox"/> Time   | [ ] Place     | <input type="checkbox"/> Person  | [ ] Comments _____           |
| Mood and Affect | <input type="checkbox"/> Normal | [ ] Depressed | <input type="checkbox"/> Anxious | [ ] Agitated [ ] Other _____ |

**Gynecologic**

|                     |                                 |  |
|---------------------|---------------------------------|--|
| Breasts             | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal _____        |
| Rectal              | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal _____        |
| Ext. Genitalia      | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal _____        |
| Urethra             | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal _____        |
| Bladder             | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal _____        |
| Vagina/Pe Ivic Supp | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal _____        |
| Cervix              | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal _____ Uterus |
|                     | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal _____        |
| Adnexa              | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal _____        |
| Anus/Rectum         | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal _____        |

|             |       |
|-------------|-------|
| Impression: | Plan: |
|-------------|-------|