



Helping  
women heal  
themselves

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## Annual History

Date: \_\_\_\_\_  
Name: \_\_\_\_\_ DOB/Age: \_\_\_\_\_/\_\_\_\_\_  
Reason for today's visit: \_\_\_\_\_  
\_\_\_\_\_

Last menstrual period began: \_\_\_\_\_ Prior period began: \_\_\_\_\_  
Any changes in period? \_\_\_\_\_

Currently sexually active? \_\_\_\_\_ Birth control method: \_\_\_\_\_  
Any sexual or relationship problems? \_\_\_\_\_  
\_\_\_\_\_

Have you had any recent, or current problems with:

___ Insomnia	___ Depression	___ Mood swings	___ Urinary incontinence
___ Hot flashes	___ Low sex drive	___ Weight gain	___ Pain with intercourse
___ Night sweats	___ Breast tenderness	___ Joint tenderness	___ Abdominal bloating
___ Palpitations	___ Vaginal dryness	___ Memory loss	

___ Head	___ Eyes	___ Ears	___ Sinuses	___ Throat	___ Chest
___ Lungs	___ Heart	___ Stomach	___ Abdomen	___ Bowels	___ Urine
___ Back	___ Joints	___ Skin	___ Hair	___ Weight	
___ Other: _____					

Please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Operations since last visit: \_\_\_\_\_  
Illnesses since last visit: \_\_\_\_\_  
Any NEW allergies: \_\_\_\_\_  
Any NEW family history: \_\_\_\_\_

Current medications/supplements: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Last cholesterol: \_\_\_\_\_ Last mammogram: \_\_\_\_\_  
Last Bone Density: \_\_\_\_\_ Last colonoscopy: \_\_\_\_\_  
Dietary Preferences/Restrictions: \_\_\_\_\_

Sample of Daily Menu:

Breakfast: \_\_\_\_\_  
Lunch: \_\_\_\_\_  
Dinner: \_\_\_\_\_

Routine Exercise: Type: \_\_\_\_\_ Duration: \_\_\_\_\_ How often? \_\_\_\_\_

Tobacco? ☐ No; ☐ Yes-- Type: \_\_\_\_\_ How much? \_\_\_\_\_ How long? \_\_\_\_\_

Alcohol use? ☐ No; ☐ Yes-- How much? \_\_\_\_\_ How often? \_\_\_\_\_

Caffeine use? ☐ No; ☐ Yes-- How much? \_\_\_\_\_ How often? \_\_\_\_\_

Other mood altering substance use (i.e. marijuana, cocaine—past and present): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Any special concerns today: \_\_\_\_\_

Annual History - continued

# Annual Exam

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

Name: \_\_\_\_\_ DOB/Age: \_\_\_\_\_ / \_\_\_\_\_

G: \_\_\_\_\_ P: \_\_\_\_\_

LMP: \_\_\_\_\_ HT: \_\_\_\_\_

WT: \_\_\_\_\_ BP: \_\_\_\_\_

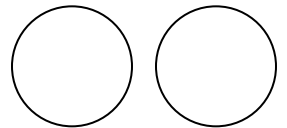
P: \_\_\_\_\_ UA: \_\_\_\_\_

HGB: \_\_\_\_\_

Other Lab: \_\_\_\_\_

	Use WNL or
Skin	
Heent	
Neck	
Breasts	Taught SBE <input type="checkbox"/>
Lungs	
Heart	
Abdomen	
Extremities	✓
Neurologic	
Ext. Genitalia	
Vagina	
Cervix	
Fundus	RV <input type="checkbox"/> AV <input type="checkbox"/> Mid <input type="checkbox"/>
Adnexa	
R-V	

A:



P: