1. Please indicate your present method of birth control.  
   YES  NO

2. Do you think you might be pregnant?

3. Your last menstrual period began on _____/_____/_____

4. Write in any changes related to your period:______________________________

5. Have you noticed any unusual vaginal odor, discharge, or itching?

6. Are you sexually active?
   If yes, how many partners have you had in the past year?________
   If yes, do you have pain during intercourse? Y / N

7. How would you describe your sexuality? (circle one) Heterosexual  Lesbian  Bisexual  Not Sexually Active

8. Are you worried you might have a sexually transmitted disease?

9. Have you ever been diagnosed with Gonorrhea, Chlamydia, Herpes, Syphilis, or HIV/AIDS?
   If yes, when and where were you treated? __________________________________

10. Have you found any abnormalities while examining your breasts?

11. Have you ever had an abnormal finding on a mammogram?
   Date and place of last mammogram ________________________________________

12. Have you had a pelvic ultrasound done within the last 12 months?
   If yes, date and place of ultrasound ________________________________

13. Since your last visit have you had any recent operations, serious illnesses, or injuries?
   If yes, describe____________________________________________________________

14. Are there any other problems you would like to discuss with me?
   If yes, describe__________________________________________________________

15. Please list the Pharmacy of your choice if a prescription is needed: