1. Please indicate your present method of birth control. YES NO
   None, or ________________________________

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: ________________________________________________