YEARLY QUESTIONNAIRE

As your healthcare provider, our concern is **your** needs! This sheet helps us care for you better. Under each heading, please **CIRCLE** any or all that apply. Feel free to write additional comments. Thanks!

1. Are you experiencing any problems that are **NOT BEING ADDRESSED BY OTHER PHYSICIANS**
   such as: Mental Hearing Vision Lung Heart Other_____? NO

2. Are you experiencing any problems with your **breasts**? YES NO
   IF YES: Nipple Discharge Lump Tenderness Other

3. Are you having any problems with your **bladder**? YES NO
   IF YES:Frequent Bladder Infections Frequent Urination Urgency
   Leaking- only with laughing, coughing, sneezing -at most anytime

4. Are you experiencing any **intestinal** problems? YES NO
   IF YES: Abdominal Pain Frequent Loose Stools Chronic Constipation Rectal Bleeding
   Dark Red or Black Stools Difficulty Pushing Out a Bowel Movement Other

5. Are you sexually active? YES NO If yes, with a man? YES NO
   IF YES, are you experiencing any problems with **intercourse**? YES NO
   IF YES: Difficulty Lubricating Pain At The Entrance Abnormal Discharge
   Deep Pain Low Sex Drive Difficult With Orgasm

6. If you have menstrual cycles, do you have any **cycle** problems? NO
   YES: Too Heavy Significant Cramps Too Long Abnormally Irregular PMS

7. Do you experience any **menopausal** symptoms? NO
   YES: Hot Flushes Mood Swings Night Sweats Vaginal Dryness

8. If you are **over 40**, have you had any of the following performed in the last 3 years? NO
   Cholesterol Glucose Thyroid Colonoscopy

9. Do you feel that you get adequate **calcium** in your diet? YES NO
10. Do you feel that you get adequate **fiber** in your diet? YES NO

11. Do you **exercise** regularly? YES NO
12. Do you experience significant **moodiness**? YES NO Or significant **depression**? YES NO
13. Do you feel **safe,** secure, in your current living arrangement? YES NO
14. Are you experiencing any other problems you would like to discuss during the exam? YES NO
    Please explain: **In Private**? YES NO

Thank you for taking time to fill out this questionnaire, allowing us to serve you better!
Braden Richmond, MD., FACOG

NAME (Signature): _____ DATE: