Well – Woman Exam

Date ____________________

To help your doctor during today's health exam, please complete items 1 through 12.

1. Age ______________

First day of last menstrual period (or first year of menstruation, if through menopause): ________________

Date of last pap smear: ________________

2. Number of times pregnant: ________________

Number of children delivered: ________________

If you are pre-menopausal, what method of birth control do you use? ________________

If pills, what kind? ________________

How many years have you used the pills? ________________

Are you planning a pregnancy in the next 6-12 months? __________

3. Do you take any of the following pills?

Calciums	☐ Yes	☐ No
Multivitamin	☐ Yes	☐ No
Estrogen (Premarin)	☐ Yes	☐ No
Progesterone (Provera)	☐ Yes	☐ No
Supplements or Herbs	☐ Yes	☐ No

4. Have you had any of the following problems:

a. Abnormal Pap smears ☐ Yes ☐ No

If yes, date: ______________ Problem: ________________

For abnormality, did you have any of the following done:

Colposcopy	☐ Yes	☐ No
Biopsies	☐ Yes	☐ No
Surgery (look, leep, cone)	☐ Yes	☐ No
b. High blood pressure,	☐ Yes	☐ No
c. Heart disease	☐ Yes	☐ No
d. High cholesterol	☐ Yes	☐ No
e. Migraine headaches, blood clot in legs or cancer	☐ Yes	☐ No
f. Blood clots in legs or lungs	☐ Yes	☐ No
g. Cancer	☐ Yes	☐ No
h. Abdominal or pelvic surgery or special tests	☐ Yes	☐ No

If yes, what: ________________ When: ______________

5. Do you have any of the following:

a. Problems with present method of birth control	☐ Yes	☐ No
b. Bleeding between periods of since periods stopped	☐ Yes	☐ No
c. Pain with intercourse or periods	☐ Yes	☐ No
d. Any problem with interest in or enjoying intercourse	☐ Yes	☐ No
e. A new or enlarging lump in breast	☐ Yes	☐ No
f. Change in size/firmness of stools	☐ Yes	☐ No
g. Change in size/color of a mole	☐ Yes	☐ No
h. Severe headaches	☐ Yes	☐ No
i. Chest pain	☐ Yes	☐ No
j. Shortness of breath	☐ Yes	☐ No
k. Stomach problems or heartburn	☐ Yes	☐ No
l. Problems with falling	☐ Yes	☐ No
m. Periods of weakness, numbness or inability to talk	☐ Yes	☐ No
n. Any painful joints	☐ Yes	☐ No
o. Trouble falling or staying asleep	☐ Yes	☐ No
p. Often feeling down, depressed or hopeless during the past month	☐ Yes	☐ No
q. Often having little interest or pleasure in doing things during the past month	☐ Yes	☐ No
r. Stress in your family or relation- ship. Has anyone hurt you?	☐ Yes	☐ No
s. Any unexplained weight changes	☐ Yes	☐ No
t. Any problems with your hearing	☐ Yes	☐ No

6. Do you have a parent, brother or sister with a history of the following:

a. Cancer of the breast, intestine or female organs	☐ Yes	☐ No
b. Heart pain or heart attacks before the age of 55	☐ Yes	☐ No

If yes to a or b:

Relation: ________________ Type: ______________

Relation: ________________ Type: ______________

NHMG

Well-Woman Exam

802830 R 03/12/2014 AS0010

Name / MR # / Label

7. Osteoporosis (thin-bone) screening:

a. Are there a history of any relatives with the following:
Stooping over, losing height as they aged, "thin bones", hip fractures ☐ Yes ☐ No

If yes, relation ______________________

b. Have you had any of the following?

Height loss	☐ Yes	☐ No
Broken hip or wrist	☐ Yes	☐ No
Bone-density test	☐ Yes	☐ No

c. Do you take any of the following?

Prednisone or other steroids	☐ Yes	☐ No
Medication for thyroid, seizures or thin bones	☐ Yes	☐ No

8. Have you ever used tobacco? ☐ Yes ☐ No
If yes:
Average number of packs/day: ______________

Number of years smoked: __________ Year quit: __________

When are you planning to quit?

☐ Now ☐ Next 6 months ☐ Sometime ☐ Never

9. Do you drink alcohol? ☐ Yes ☐ No
If yes:

a. Have you ever felt you should cut down on your drinking? ☐ Yes ☐ No
b. Have people ever annoyed you by nagging you about your drinking? ☐ Yes ☐ No
c. Have you ever felt guilty about your drinking? ☐ Yes ☐ No
d. Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover? ☐ Yes ☐ No

10. Do you use marijuana, cocaine or other street drugs? ☐ Yes ☐ No

11. Prevention:
a. Which of the following are included in your diet?

Grains and starches	☐ A lot	☐ Some	☐ Few
Vegetables	☐ A lot	☐ Some	☐ Few
Dairy foods	☐ A lot	☐ Some	☐ Few
Meats	☐ A lot	☐ Some	☐ Few
Sweets	☐ A lot	☐ Some	☐ Few
Fruits	☐ A lot	☐ Some	☐ Few
Nuts	☐ A lot	☐ Some	☐ Few

e. Have you had a tetanus shot in the past 10 years? ☐ Yes ☐ No

f. Does your house have a working smoke/carbon monoxide detector? ☐ Yes ☐ No

g. Do you have guns at home? ☐ Yes ☐ No

h. Do you feel safe at home? ☐ Yes ☐ No

i. How comfortable are you with your reading?
☐ very comfortable ☐ Somewhat comfortable ☐ No comfortable at all

j. Have you ever had a mammogram? ☐ Yes ☐ No
If yes, date of last: __________ Where: __________

Have you ever had any abnormal mammograms? ☐ N/A ☐ Yes ☐ No
If yes, date: __________ Problem: __________

For abnormality, did you have any of the following:

Biopsy	☐ Yes	☐ No
Cyst fluid drained	☐ Yes	☐ No
Surgery	☐ Yes	☐ No

k. How many sexual partners have You had in the last 12 months? ______ In your lifetime? ______

l. Do you have sex with men, women, both? __________

m. Do you practice safe sex? ☐ Yes ☐ No

n. Do you use condoms? ☐ Yes ☐ No

o. Does your partner have sex with anyone else? ☐ Yes ☐ No

j. When is the last time you had a dental check-up? ______________________

11. b. Exercise:
Activity ______________________
Days per week __________
Time/duration __________ Minutes
Exertion: ☐ Stroll ☐ Mild ☐ Heavy
c. Do you always wear seat belts? ☐ Yes ☐ No
d. Have you had your cholesterol level checked in the past five years? ☐ Yes ☐ No

12. Please describe any concerns you have: ______________________________

______________________________ *Thank you for your help.*

If limited English proficient or hearing impaired, offer interpreter at no additional cost:

☐ Interpreter Accepted ______________________________ ☐ Interpreter Refused
(Name/Number of Person/Services Chosen/Used)

Patient Signature: ______________________ Date: __________ Time: __________

Questionnaire reviewed and discussed with patient
MD/MLP Signature: ______________________ Date: __________ Time: __________