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

1. **Age**
   - c. Pain with intercourse or periods
   - d. Any problem with interest in or enjoying intercourse
   - e. A new or enlarging lump in breast
   - f. Change in size/firmness of stools
   - g. Change in size/color of a mole
   - h. Severe headaches
   - i. Chest pain
   - j. Shortness of breath
   - k. Stomach problems or heartburn
   - l. Problems with falling

2. **First day of last menstrual period (or first year of menstruation, if through menopause):**
   - a. Abnormal Pap smears
   - b. High blood pressure,
   - c. Heart disease
   - d. High cholesterol
   - e. Migraine headaches, blood clot in legs or cancer
   - f. Blood clots in legs or lungs
   - g. Cancer
   - h. Abdominal or pelvic surgery or special tests

3. **Number of times pregnant:**
   - a. Problem(s) with present method of birth control
   - b. Bleeding between periods since periods stopped

4. **Date of last pap smear:**
   - a. Cancer of the breast, intestine or female organs
   - b. Heart pain or heart attacks before the age of 55

5. **Date**
   - a. Cancer
   - b. Heart disease
   - c. Cancer
   - d. Abdominal or pelvic surgery or special tests

6. **Any problems with your hearing**
   - a. Pain with intercourse or periods
   - b. Any problem with interest in or enjoying intercourse
   - c. A new or enlarging lump in breast
   - d. Change in size/firmness of stools
   - e. Change in size/color of a mole
   - f. Severe headaches
   - g. Chest pain
   - h. Shortness of breath
   - i. Stomach problems or heartburn
   - j. Problems with falling

---

If pills, what kind?

If pills, what kind?

How many years have you used the pills?

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

---

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

Colposcopy

Biopsies

Surgery (look,leep,cone)
Well – Woman Exam

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
   d. Do you have any of the following?
      Stoop over, losing height as they aged, “thin bones”, hip fractures □ Yes □ No
   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: ________________________________
   k. How many sexual partners have you had in the last 12 months?
      □ N/A □ Yes □ No
   If yes, date: __________ Problem: ________________________________
   l. Do you have sex with men, women, both?
      □ Yes □ No
   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?
      ________________________________
   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
      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: __________