

WELL – WOMAN EXAM

To help your doctor during today's health exam, please complete items 1 through 13.

Today's Date: _____

1. Age: _____
 First day of last menstrual period (or first year of menstruation, if through menopause): _____
 2. Number of times pregnant: _____
 Number of completed pregnancies: _____
 Date of last pregnancy: _____
 If you are under age 55, what method of birth control do you use? _____
 If pills, what kind? _____
 How many years have you used the pill? _____
 Are you planning a pregnancy in the next 6-12 months?
 Yes No
 3. If you are through menopause or over age 50, do you take any of the following pills?

Calcium	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Estrogen (Premarin)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Progesterone (Provera)	<input type="checkbox"/> Yes	<input type="checkbox"/> 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	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Biopsies	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Surgery	<input type="checkbox"/> Yes	<input type="checkbox"/> No
 - b. High blood pressure, heart disease, or high cholesterol Yes No
 - c. Migraine headaches, blood clot in legs, or cancer Yes No
 - d. 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 or 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/color of stools Yes No
 - g. Change in Size/color of a mole Yes No
 - h. Severe headaches Yes No
 - i. Pain in the leg, chest, abdomen, or joints Yes No
 - j. Trouble falling or staying asleep Yes No
 - k. Often feeling down, depressed, or hopeless during the past month Yes No
 - l. Often having little interest or pleasure in doing things during the past month Yes No
 - m. Conflict in your family or relationships sometimes handled by pushing, hitting, or cruelty 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: _____
 7. Osteoporosis (thin-bone) screening:
 - a. Is there a history of any relatives with the following: stooping over or losing height as they get older, "thin bones", hip fractures Yes No
 If yes, relation: _____
 - b. Have you had any of the following:

Hair loss	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Broken hip or wrist	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bone-density test	<input type="checkbox"/> Yes	<input type="checkbox"/> No
 - c. Do you take any of the following:

Steroids (Prednisone)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Medication for thyroid, seizures, or thin bones	<input type="checkbox"/> Yes	<input type="checkbox"/> No
 8. Have you ever used tobacco? Yes No
 If yes:
 Average number of packs per day: _____
 Number of years you 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. 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

b. Exercise:

Activity: _____

Days per week: _____

Time/duration: _____ minutes

Exertions: Stroll Mild Heavy

- c. Do you always wear seat belts? Yes No
- d. If over 30 years old, have you had your cholesterol level checked in the past five years? Yes No
- e. Have you had a tetanus shot in the past 10 years? Yes No
- f. Does your house have a working smoke detector? Yes No
- g. Do you have firearms at home? Yes No
- h. 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
- i. How many sexual partners have you had in the last 12 months? _____
In your lifetime? _____
- j. When is the last time you had a dental check up? _____

11. Surgery: Yes No

List Surgeries:

12. Please describe any concerns you have:

13. Please list the current medications you are taking:

Thank you for your help