NAME:______________________________

DOB:____________________

WELL-WOMEN EXAM

To help your doctor during today's health exam, please complete items 1 through 11.

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 pills? ________

   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 ☐Yes ☐No

   Estrogen (Premarin) ☐Yes ☐No

   Progesterone (Provera) ☐Yes ☐No

4. Have you had any of the following problems:

- 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 ☐Yes ☐No

- High blood pressure, heart disease or high cholesterol ☐Yes ☐No
- Migraine headaches, blood clot in legs or cancer ☐Yes ☐No
- Abdominal or pelvic surgery or specials tests ☐Yes ☐No

  If yes, what: ________________________ when: ____________________

5. Do you have any of the following?

- Problems with present method of birth control ☐Yes ☐No
- Bleeding between periods or since periods stopped ☐Yes ☐No
- Pain with intercourse or periods ☐Yes ☐No
- Any problem with interest in or enjoying intercourse ☐Yes ☐No
- A new or enlarging lump in breast ☐Yes ☐No
- Change in size/firmness of stools ☐Yes ☐No
- Change in size/color of a mole ☐Yes ☐No
- Severe headaches ☐Yes ☐No
- Pain in the leg, chest, abdomen or joints ☐Yes ☐No
- Trouble falling or staying asleep ☐Yes ☐No
- Often feeling down, depressed or hopeless during the past month ☐Yes ☐No

NAME:______________________________

DOB:____________________

- Often having little interest or pleasure in doing things during the past month ☐Yes ☐No
- 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:

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

  If yes to either one:

  Relation______________ Type: ___________________

  Relation______________ Type: ___________________

  Relation______________ Type: ___________________

7. Osteoporosis (thin-bone) screening:

- Is there a history of any relatives with the following:

  Stooping over or losing height as they got older, "thin bones," hip fractures ☐Yes ☐No

  If yes, relation: _________________

- Have you had any of the following:

  Height loss ☐Yes ☐No

  Broken hip or wrist ☐Yes ☐No

  Bone-density test ☐Yes ☐No

- Do you take any of the following:

  Steroids (prednisone) ☐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:

- Have you ever felt you should cut down on your drinking? ☐Yes ☐No
- have people ever annoyed you by nagging you about your drinking? ☐Yes ☐No
- Have you ever felt guilty about your drinking? ☐Yes ☐No
- 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:

- 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

- Exercise:

NAME: ______________________________
DOB: ____________________

Activity ______________________
Days per week ______________________
Time/duration ____________minutes
Exertion: ☐Stroll ☐Mild ☐Heavy

- Do you always wear seat belts? ☐Yes ☐NO
- If over 30 years old, have you had your cholesterol level checked in the past five years? ☐Yes ☐NO
- Have you had a tetanus shot in the past 10 years? ☐Yes ☐NO
- Does your house have a working smoke detector? ☐Yes ☐NO
- Have you ever had a mammogram? ☐Yes ☐NO

If yes, date of last: ____________ where: ________________

For abnormality, did you have any of the following:

Biopsy ☐Yes ☐NO
Cyst fluid drained ☐Yes ☐NO
Surgery ☐Yes ☐NO

- How many sexual partners have you had in the last 12 months? ______ In your lifetime? ______
- When is the last time you had a dental check-up? ________

11. Please describe any concerns your have:

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Thank you for helping us get to know you!