Well Woman Exam Questionnaire

Are you concerned about any of the following? (circle yes or no and specific problem)

Eating habits: weight gain or loss, sleep habits
Eye redness, pain, increased tearing, drainage, blurred, decreased vision
Ear pain, decreased hearing
Heart problems, chest pain, palpitations, blood pressure, leg swelling
Lung problems, difficulty breathing, wheezing, cough
Abdominal pain, nausea, vomiting, diarrhea, constipation, bloody stool
Kidney or bladder problems, infection, blood in urine
Joint pain, stiffness, swelling, muscles pain or weakness
Skin, rash, itching, dryness, hair or nail problems
Recurrent headaches, dizziness, numbness, weakness
Stress, anxiety, sadness, depression, suicidal thoughts
Excessive thirst or hunger, increased urination, weight loss
Paleness, anemia, easy bruising, swollen glands
Allergies, hay fever, asthma, infections

Comments

_________________________  __________   __________

Personal History

Are you concerned about any of the following? (circle yes or no)

Menstruation
Pain or bleeding with intercourse
Vaginal itching or discharge
Sexually transmitted diseases, AIDS, other sexual concerns

Comments

Do you have menstrual periods?

Date of last menstrual period

Have you ever had a PAP smear?

Date of last PAP smear

Have you ever had a mammogram?

Date of last mammogram

Are you sexually active?

If you are sexually active, do you use birth control?

What method?

Have you had more than 4 lifetime partners?

How many:

Pregnancies    Live births    miscarriages    Abortions?
Name_________________________________ Date of Birth____________________

Social History
Are you: single married divorced widowed?
Do you feel safe at home, in your relationships with family/partner? yes no
Do you smoke or use tobacco products? yes no
If yes, how many packs/cans per day? How many years?
Do you use recreational drugs? yes no
If yes, type frequency?
Do you drink alcohol? yes no
If yes, how many per day? per week?
Do you always use a seat belt in a vehicle? yes no

Preventative Health History
Have you ever had a colonoscopy? yes no
Have you ever had your cholesterol checked? yes no
When? Was it normal? yes no
Have you had a tetanus shot in the past 10 years? yes no
When?

Personal/Family History
Have you had any of the following?
Breast cancer yes no when?
Uterine cancer yes no when?
Ovarian Cancer yes no when?
Cervical Cancer yes no when?
Colon Cancer yes no when?
Osteoporosis yes no when?
Heart disease yes no when?
Heart attack before age 55 yes no when?

Have any close relatives had any of the following?
Breast Cancer yes no who?
Uterine Cancer yes no who?
Ovarian Cancer yes no who?
Cervical Cancer yes no who?
Osteoporosis yes no who?
Heart Disease yes no who?
Heart attack before the age of 55 yes no who?

Do you have any concerns you wish to discuss?
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________

Patient signature_________________________ Date________________