Flathead Valley Community College

# Student Health Clinic

**Name**_____ **Date of Birth**_____

## 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……yes no
Eye redness, pain, increased tearing, drainage, blurred, decreased vision …….. yes no
Ear pain, decreased hearing …… yes no
Heart problems, chest pain, palpitations, blood pressure, leg swelling ……yes no
Lung problems, difficulty breathing, wheezing, cough …… yes no
Abdominal pain, nausea, vomiting, diarrhea, constipation, bloody stool ……yes no
Kidney or bladder problems, infection, blood in urine …… yes no
Joint pain, stiffness, swelling, muscles pain or weakness …… yes no
Skin, rash, itching, dryness, hair or nail problems ……yes no
Recurrent headaches, dizziness, numbness, weakness ……yes no
Stress, anxiety, sadness, depression, suicidal thoughts …… yes no
Excessive thirst or hunger, increased urination, weight loss ……yes no
Paleness, anemia, easy bruising, swollen glands …… yes no
Allergies, hay fever, asthma, infections …… yes no

**Comments**_____
_____

**Personal History**

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

Menstruation ……yes no
Pain or bleeding with intercourse ……yes no
Vaginal itching or discharge……yes no
Sexually transmitted diseases, AIDS, other sexual concerns ……yes no

**Comments**_____
_____

Do you have menstrual periods? …… yes no
Date of last menstrual period _____
Have you ever had a PAP smear? ……yes no
Date of last PAP smear _____ Was it normal? ……yes no
Have you ever had a mammogram?……yes no
Date of last mammogram_____Was it normal?.....yes no
Are you sexually active? ……yes no
If you are sexually active, do you use birth control?……yes no
What method? _____
Have you had more than 4 lifetime partners?……yes no
How many:
Pregnancies_____ Live births _____ miscarriages _____ Abortions _____?

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**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 or have you ever used 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

Exercise information: Do you exercise regularly?_____What type and how often?_____

_____

**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 **<u>you</u>** 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 **<u>close relatives</u>** 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**_____