WELL-WOMAN EXAM **Patient Name:** **Date of Birth:**

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:

a. 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

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 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 got older, "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:

Steroids (prednisone) • YES • NO

Medication for thyroid, seizures or thin bones • YES • NO

Form continues on next page >

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:

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

Exertion: • 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? • N/A • 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. Please describe any concerns you have:

_____
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Thank you for your help.

Patient Signature Date