WELL-WOMAN EXAM

Name_____

Date of Birth_____

Please complete items 1 through 11 (2 pages – front and back)

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 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 >

Name:_____

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? m 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. Describe additional concerns you have:

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Disclaimer:

AHFP utilizes GenPath as its preferred Laboratory for gynecological specimens. Many Gynecologists utilize GenPath as well, due to their high quality testing techniques. Your insurance company may require you to pay a deductible portion of your well-woman lab costs. Therefore, if you receive a bill from GenPath it will be your responsibility to pay these charges.
If you have any questions regarding your insurance company's policy, please contact them in advance of your appointment.

Reviewed by Practitioner:

Signature: _____

Date: _____