

WELL-WOMAN EXAM

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

Name _____

Today's Date _____

Date of Birth _____

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	<input type="checkbox"/> a lot	<input type="checkbox"/> some	<input type="checkbox"/> few
Vegetables	<input type="checkbox"/> a lot	<input type="checkbox"/> some	<input type="checkbox"/> few
Dairy foods	<input type="checkbox"/> a lot	<input type="checkbox"/> some	<input type="checkbox"/> few
Meats	<input type="checkbox"/> a lot	<input type="checkbox"/> some	<input type="checkbox"/> few
Sweets	<input type="checkbox"/> a lot	<input type="checkbox"/> some	<input type="checkbox"/> 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? 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	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Cyst fluid drained	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Surgery	<input type="checkbox"/> YES	<input type="checkbox"/> 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? _____

Disclaimer:

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Patient

Signature: _____

Date: _____