WELL-WOMAN EXAM

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

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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.

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