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WELL-WOMAN EXAM

Name ________________________________ Date ___________

1. Date of birth: ________________ Age: ___________
   First day of last menstrual period (or first year of menstruation, if through menopause): _________________
   Have you had a hysterectomy? YES ☐ NO ☐
   Were your ovaries removed? YES ☐ NO ☐

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/Estradiol YES ☐ NO ☐
   Progesterone/Prometrium 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 clots in legs or cancer YES ☐ NO ☐
   d. Abdominal or pelvic surgery or special tests or hysterectomy 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 ☐
   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 or 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 ☐

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 to 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 5 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? 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? ___________
   How many in your lifetime? ___________
   j. When is the last time you had a dental check-up? _______

Please describe any concerns you have:___________________
____
____

Medications: ____
____
____
____

Pharmacy: ____

__For Practitioner Use__

Patient counseled regarding: ____
____
____

Labs ordered: ____
____

UA: Bacteria: __________ Blood: __________ Nitrates: __________ Glucose: __________ Ketones: __________ UCG: __________

Provider: ________________________________ Supervising provider: _______________________________ Date: ________________