WELL WOMAN QUESTIONNAIRE

NAME: _____ Date _____

Gynecologic History

First day of last mentrual period: _____
How many days in between your cycles? _____
How long does your period last? _____
Have you ever taken any hormone replacement therapy?
If yes, when? _____ YES NO
If you are post-menopause, have you had any bleeding since you went through menopause? YES NO

Mammogram History

Have you ever had a mammogram? YES NO
If yes, when: _____
Have you ever had an abnormal mammogram? YES NO
If yes, when: _____
For the abnormality did you have any of the following? Biopsy YES NO
Cyst fluid drained YES NO
Surgery YES NO

Pregnancy History

Number of times you have been pregnant: _____
Number of completed pregnancies: _____
Vaginal deliveries: _____ C-section: _____

Family Planning

Are you sexually active? YES NO
What do you use for birth control? _____
_____

Have you ever had an STD? YES NO
If yes, what kind? _____

Pap History

Have you ever had an abnormal pap? YES NO
If yes, what was the date: _____
For the problem, were these performed?
Colposcopy: YES NO

Pelvic/Abdominal Surgeries

Have you had any recent surgeries? YES NO
If yes, what was the date? _____
What was the purpose?_____
_____

Osteoporosis History

Have you ever been screened for Osteoporosis? YES NO
If yes, what was the date? _____
Results of the exam: _____
Have you ever been on Depo Provera for birth control?
Yes No If yes, for how long _____

Past Medical History

Please circle if YOU have now or have ever had any of these medical conditions:
High Blood Pressure Heart Disease Anemia
High Cholesterol Migraine Asthma Arthritis
Blood Clots (where_____) Depression
Cancer (what kind?_____) Diabetes Anxiety
Skin Disorder (what kind? _____) Allergies
Lung Disease (COPD Emphysema Asthma)

Family History

Do you have a parent or sibling with a history of colon, breast, uterine or ovarian cancer or ostoporosis, or heart disease or depression? YES NO
If yes, who was it & what did they have?_____
_____

Prevention History

Do you eat a well-balanced diet that is also low in sugar and fats? YES NO
Do you exercise regularly? YES NO
How many days a week? _____
How long do you exercise for? _____
What kind of exercise?_____
_____
When was your last Tetanus shot? _____
When was your last Flu shot? _____

Have you ever had a chest xray? YES NO
If yes, when? _____

When was your last dental cleaning? _____

Review of Systems

Please circle below anything that you have experienced CHRONICALLY or RECENTLY. (The provider may ask for you to return for another office visit to adequately address any complicated issues)

General: fever chills fatigue general weakness

Eyes: visual disturbances eye irritation

Ears, Nose & Throat: runny nose sore throat nosebleeds ear pain trouble hearing

Heart: chest pain chest palpitation difficulty breathing on exertion passing out

Lungs: trouble breathing coughing spitting up phlegm wheezing

Breast: lumps skin changes drainage from the nipple

Abdomen: abdominal pain diarrhea constipation nausea vomiting

Urinary: urinating more than usual burning when urinating trouble holding urine retaining urine

Rectal: rectal bleeding black stools constipation change in firmness of stools

Genitals: vaginal discharge vaginal irritation irregular periods pain during intercourse

Skin: rash moles that have recently appeared or changed in size or color

Neuro: headaches numbness or tingling weakness in one body part dizziness speech problems

Musculosketal: joint pain joint swelling neck pain joint deformity

Psych: trouble sleeping conflict in family or personal relationships that is sometimes handled by pushing/hitting/cruelty feeling depressed feeling anxious thoughts of hurting yourself/anyone else