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
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

Form continues on next page ➤

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:

____
____
____
____
____
____
____
____
____
____
____
____
____
____

Thank you for your help.

continued ➤