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  ○ YES  ○ NO
   in the next 6-12 months?

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: ____________________________
      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
      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

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9. Do you drink alcohol?  
   O YES  O NO
If yes:
   a. Have you ever felt you should cut down on your drinking?  O YES  O NO
   b. Have people ever annoyed you by nagging you about your drinking?  O YES  O NO
   c. Have you ever felt guilty about your drinking?  O YES  O NO
   d. Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover?  O YES  O NO

10. Prevention:
   a. Which of the following are included in your diet:
      Grains and starches  O a lot  O some  O few
      Vegetables  O a lot  O some  O few
      Dairy foods  O a lot  O some  O few
      Meats  O a lot  O some  O few
      Sweets  O a lot  O some  O few
   b. Exercise:
      Activity _______________________
      Days per week ________
      Time/duration ________ minutes
      Exertion:  O stroll  O mild  O heavy
   c. Do you always wear seat belts?  O YES  O NO
   d. If over 30 years old, have you had your cholesterol level checked in the past five years?  O YES  O NO
   e. Have you had a tetanus shot in the past 10 years?  O YES  O NO
   f. Does your house have a working smoke detector?  O YES  O NO
   g. Do you have firearms at home?  O YES  O NO
   h. Have you ever had a mammogram?  O YES  O NO
      If yes, date of last: ________ where: __________________________
      Have you ever had any abnormal mammograms?  O N/A  O YES  O NO
      If yes, date: ________ problem: __________________________
      For abnormality, did you have any of the following:
      Biopsy  O YES  O NO
      Cyst fluid drained  O YES  O NO
      Surgery  O YES  O 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.