UCCS HealthCircle Primary Care Clinic
UNIVERSITY OF COLORADO COLORADO SPRINGS

Well-Woman Exam History Form

(To help your practitioner during today's exam, please complete items 1-10)

Name: _____ Date of Birth: _____ Today's Date: _____

1. Age: _____ First year of menstruation: _____ First day of last menstrual period: _____

How long does your period last? _____ Is your period? ☐Heavy ☐Moderate ☐Light

2. Number of times pregnant: _____ Number of pregnancies _____ Number of full-term live births: _____

Preterm births: _____ Spontaneous or induced abortions: _____ Living children: _____

Date of last pregnancy: _____ Are you planning to get pregnant? ☐ YES ☐NO

What birth control method do you use? _____

3. If you are finished with menopause or over 50, do you take any of the following pills? **(Check the type if YES)**:

☐Calcium ☐Estrogen (Premarin) ☐Progesterone (Provera) ☐Prednisone

4. **Have you had any of the following problems? (If YES Check the box and explain)**

a. Abnormal Pap smears ☐ YES ☐ NO
If YES, date _____ problem: _____
For abnormality, did you have any of the following…
Colposcopy ☐ YES ☐ NO
Biopsies ☐ YES ☐ NO
Surgery ☐ YES ☐ NO

b. Severe headaches ☐ YES ☐ NO

c. Blood clots in your legs ☐ YES ☐ NO

d. Pelvic surgery ☐ YES ☐ NO
If YES, surgery type _____
Date: _____

e. Problems with present method of birth control ☐ YES ☐ NO

f. Bleeding between periods or since periods stopped ☐ YES ☐ NO

g. Pain with intercourse or with periods ☐ YES ☐ NO

h. A new or changing breast lump ☐ YES ☐ NO

i. Decreased interest or enjoyment in sex ☐ YES ☐ NO

j. Change in your stools, size or texture ☐ YES ☐ NO

k. Kidney infections ☐ YES ☐ NO

l. Kidney stones ☐ YES ☐ NO

m. Anxiety ☐ YES ☐ NO

n. Eating Disorder ☐ YES ☐ NO

o. Anemia ☐ YES ☐ NO

p. Problems sleeping ☐ YES ☐ NO

q. Feeling down, depressed or hopeless in the past month ☐ YES ☐ NO

r. Have little interest or pleasure in doing things in the past month ☐ YES ☐ NO

s. Been a victim of domestic violence ☐ YES ☐ NO

t. Been a victim of sexual abuse ☐ YES ☐ NO

u. Vaginal or pelvic infections ☐ YES ☐ NO

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5. Do you have a parent, brother or sister with a history of the following problems?

a. Cancer of the breast, female reproductive organs or intestines ☐ YES ☐ NO

b. Heart attacks before the age of 55 ☐ YES ☐ NO

6. Osteoporosis (weak, thin bones)

a. Is there a history of any relatives who were stooped over, had broken bones or lost height? ☐ YES ☐ NO

If YES, who_____

b. Have you ever had any of the following:

Loss of height ☐ YES ☐ NO

Broken Hip or wrist ☐ YES ☐ NO

Bone Density Testing ☐ YES ☐ NO

7. Have you ever used tobacco?

If you have or do…

a. Number of packs/day: _____

b. Number of years smoking: _____

c. Year you quit: _____

d. Do you plan to quit?

☐Now ☐In 6 months ☐Sometime ☐Never

8. Do you drink alcohol?

If you do….

a. Have you been annoyed by someone talking to you about your drinking? ☐ YES ☐ NO

b. Have you felt like you should cut down on the amount that you drink? ☐ YES ☐ NO

c. Have you ever felt guilty about the amount of alcohol that you drink? ☐ YES ☐ NO

d. Have you ever had a drink right after you woke up in the morning? ☐ YES ☐ NO

9. Prevention: (Check all that apply)

a. How often do you exercise?

☐ never ☐ once a week ☐ 2-4 x a week

☐ 5-7 x a week

What is your activity? _____

How long do you exercise? _____

Intensity? _____

b. Do you wear seatbelts? ☐ YES ☐ NO

c. Do you use sunscreen?

☐ All the time ☐ Most of the time

☐ Some of the time ☐ Never

d. What does your diet consist of:

Whole grains ☐ many ☐ some ☐ few

Vegetables ☐ many ☐ some ☐ few

Dairy foods ☐ many ☐ some ☐ few

Lean cuts of meat ☐ many ☐ some ☐ few

Sweets and Fats ☐ many ☐ some ☐ few

Caffeinated drinks ☐ many ☐ some ☐ few

Processed Foods ☐ many ☐ some ☐ few

Fast Foods ☐ many ☐ some ☐ few

Sodas ☐ many ☐ some ☐ few

Water ☐ many ☐ some ☐ few

e. Have you had a tetanus shot in the last 10 years? ☐ YES ☐ NO

f. Have you ever had a mammogram? ☐ YES ☐ NO

If YES, date of last? _____

Any abnormal mammograms? ☐ YES ☐ NO

If YES, date _____

What was the problem _____

For abnormal results, did you have any of the following? ☐ biopsy ☐ cyst drained ☐ surgery

g. How many sexual partners in the last 12 months? _____

In your lifetime? _____

h. Have you had your cholesterol checked? ☐ YES ☐ NO

10. Other Concerns

_____

_____

_____

_____

_____