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 (Progvera) ☐ 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
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

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
    ____________________________________________
    ____________________________________________
    ____________________________________________
    ____________________________________________
    ____________________________________________