

Name: _____

Date: _____

WELL-WOMAN EXAM

To help your doctor during today's health exam, please complete items 1 through 11.

1. Age: _____
First year of menstruation: _____
First day of last period or age at 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

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- 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

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? 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 checkup? _____

- k. Do you take Vitamin D? _____

- l. Do you take any other vitamins, herbs, supplements or natural remedies? _____

- m. Do you meditate, do yoga, or participate in any form of relaxation? _____

- n. Are spirituality or religion part of your life? _____

11. Please describe any concerns you have:

Thank you for your help.