

Date: _____

WELL-WOMAN EXAM

Name: _____

Dob: _____

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: _____ 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 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