

Label

**Well-Woman Preventative Exam**

Preferred Name: \_\_\_\_\_ Age: \_\_\_\_\_ LMP (1<sup>st</sup> day): \_\_\_\_\_

Do you have other concerns you would like to address at this visit?  
\_\_\_\_\_

**The following questions will help your provider determine the recommended services offered to you at your visit.**

Over the past 2 weeks, how often have you been bothered by any of the following: *(Please x response)*

	0- Not at all	1- Several days	2- More than ½ the days	3- Nearly every day
1. little interest or pleasure in doing things				
2. feeling down, depressed or hopeless				

Have you been pregnant or delivered a child since your last visit with us? \_\_\_ No \_\_\_ Yes

Within the last year, have you had any new diagnosis of a medical condition? \_\_\_ No \_\_\_ Yes, please list:  
\_\_\_\_\_

Have you had surgery performed within the last year? \_\_\_ No \_\_\_ Yes, please list:  
\_\_\_\_\_

Please list any new allergies to medications/drugs or food since your last visit with us: \_\_\_\_\_

**PREGNANCY HISTORY**

How many times have you been pregnant? \_\_\_\_\_ Number of children living? \_\_\_\_\_ Any twins? \_\_\_\_\_  
 Vaginal delivery \_\_\_\_\_ Cesarean Section \_\_\_\_\_ VBAC \_\_\_\_\_ Miscarriage \_\_\_\_\_ Abortion \_\_\_\_\_ Ectopic \_\_\_\_\_  
 If you had a miscarriage or abortion, did you take pills or have a D&C procedure? \_\_\_ No \_\_\_ Yes, which \_\_\_\_\_

**FAMILY HISTORY** In the last year has any immediate family been diagnosed with? *please list below*  None

Breast Cancer \_\_\_\_\_ Colon Cancer \_\_\_\_\_

Ovarian Cancer \_\_\_\_\_ Other Cancer \_\_\_\_\_

**CONTRACEPTION** *(Skip section if no longer having periods)*

What is your current method of birth control? \_\_\_\_\_

Are you satisfied with your current method? \_\_\_ No \_\_\_ Yes Do you want to change? \_\_\_ No \_\_\_ Yes

Are you thinking of conceiving in the next year? \_\_\_ No \_\_\_ Yes

**SEXUAL HEALTH**

Are you sexually active? \_\_\_ No \_\_\_ Yes Partners: \_\_\_ Male \_\_\_ Female

Have you had more than one partner this year? \_\_\_ No \_\_\_ Yes

Any problems with intercourse? \_\_\_ No \_\_\_ Yes

Have you been hit, kicked, punched, or otherwise hurt by someone in the past year?  No  Yes

Do you feel safe in your current relationship?  No  Yes

Is there a partner from a previous relationship who is making you feel unsafe now?  No  Yes

**MENSTRUAL HISTORY**

Still having periods, please answer the following:

Are you experiencing period problems you would like to discuss? \_\_\_ No \_\_\_ Yes

No longer having periods, please answer the following:

Are you taking or have you taken hormone therapy? No \_\_\_ Yes: past use \_\_\_ currently taking \_\_\_

**SOCIAL HISTORY**

Do you currently use tobacco products? No \_\_\_ Yes \_\_\_; are you ready to quit? \_\_\_ No \_\_\_ Yes

How often do you use:

- Tobacco?  Never  Current/daily Type: \_\_\_\_\_  Former year quit: \_\_\_\_\_
- E-Cigarette?  Never  Current/daily  Former year quit: \_\_\_\_\_
- Smokeless Tobacco?  Never  Current/daily  Former year quit: \_\_\_\_\_
- Alcohol?  Never  Current/daily  Socially  Former year quit: \_\_\_\_\_
- Marijuana?  Never  Current/daily  Socially  Former year quit: \_\_\_\_\_
- Recreational Drugs?  Never  Current/daily Type: \_\_\_\_\_  Former year quit: \_\_\_\_\_

**PREVENTATIVE HEALTH HISTORY**

Have you had a blood test for Hepatitis C?  No  Yes  Unsure/Unknown

Date of your last Pap Smear \_\_\_\_\_ Was it normal?  No  Yes

Date of your last Mammogram \_\_\_\_\_ Location \_\_\_\_\_  N/A

Date of your last Colonoscopy \_\_\_\_\_  N/A

Date of your last DEXA/bone scan \_\_\_\_\_  N/A

**REVIEW OF SYMPTOMS:**

Check any of the following that you are CURRENTLY EXPERIENCING  None

- General:  Extreme fatigue  Depression  Fever
- Weight gain \_\_\_\_\_lbs  Weight loss \_\_\_\_\_lbs  Cold intolerance  Heat intolerance
- Skin:  Rash  Change in mole
- Respiratory/Cardiac:  Shortness of breath  Cough  Chest pain  Palpitations
- Breast:  Lump  Pain  Redness  Nipple discharge
- Gastrointestinal:  Abdominal pain  Black or bloody stools  Bloating  Diarrhea
- PMS symptoms \_\_\_\_\_
- Menopausal symptoms \_\_\_\_\_
- Vaginal discharge \_\_\_\_\_
- Urinary:  Loss of urine  Pain with urination  Urinary frequency  Urgency
- Musculoskeletal:  Muscle aches  Muscle weakness
- Neurologic:  Change in headaches  Dizziness  Numbness

Clinic Use Only: Height \_\_\_\_\_ Weight \_\_\_\_\_ BP \_\_\_\_\_

Orders:  Pap smear  Mammogram  DXA  STI  CT/GC  Labs  Immunization \_\_\_\_\_  Referral

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