Stanford HEALTH CARE
STANFORD MEDICINE

Well Woman Preventative Exam Questionnaire Please complete the following and return to our office thru the MyHealth. **We would greatly appreciate receiving this completed 2-3 days before your well-woman visit**.

Your name: ____________________________________ Date of Birth: ____________________

Preventative well care visits are for services and referrals for recommended services based on age and risk factors. These services include height, weight and blood pressure measurements, breast and pelvic exams, pap smear and sexually transmitted infections test collection, referral orders for mammogram, bone density or colonoscopy procedures. This visit will also include discussion of contraception, menstruation, ideal body mass and healthy lifestyle options available to you.

If you have a concern other than what is mentioned above and would like to address it at your visit, additional time will be needed and you may incur additional charges and be subject to a co-pay.

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

Have you been pregnant or delivered a child since your last visit with us? ❑ No ❑ Yes
Within the last year, have you had new diagnosed medical conditions?
____
Within the last year, have you had surgery performed?
____

MENSTRUAL HISTORY

Still having periods, please answer the following: Date of your last menstrual period___________________
Do you have pain associated with your periods? □ No □ Yes □ Occasionally
Any problems with your period? *(please list)*: ____

No longer having periods, please answer the following: Are you post-menopausal? ❑ No ❑ Yes
If yes, have you taken hormone therapy? □ No □ Yes, in the past □ Yes, currently taking

CONTRACEPTION *(please complete if applicable)*

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 Partner Gender: □ Male □ Female □ Both

Any problems with intercourse? ❑ No ❑ Yes, please list:______________________________________

FAMILY HISTORY

Any **new** family history of **Breast Cancer?** No Yes, relationship/age of onset______________________

Any **new** family history of **Colon Cancer?** No Yes, relationship/age of onset______________________

Any **new** family history of **Ovarian Cancer?** No Yes, relationship/age of onset______________________

Any **new** family history of Other **Cancer?** No Yes, relationship/age of onset______________________

SOCIAL HISTORY

Over the past 2 weeks, how often have you been bothered by little interest or pleasure in doing things?

Not at all (0)   Several days (1)   More than ½ the days (2)   Nearly every day (3)

Over the past 2 weeks, how often have you been bothered by feeling down, depressed or hopeless?

Not at all (0)   Several days (1)   More than ½ the days (2)   Nearly every day (3)

Has anyone forced you to have sexual activities that made you feel uncomfortable? ❑ No ❑ Yes

Are you in a relationship with a person who threatens or physically hurts you? ❑ No ❑ Yes

PREVENTATIVE HEALTH HISTORY

14 years of age and older   Have you had the Human Papilloma Virus Immunization (Gardasil)? □ No □ Yes

If yes, when (year) was the series completed: ____________

21 years of age and older: Date of your last Pap Smear_________________   Was it normal? □ No □ Yes

Have you ever had an abnormal pap smear? □ No □ Yes   What year? _____________________

Have you ever had a colposcopy for an abnormal pap smear? □ No □ Yes

Have you had treatment for abnormal pap smear? □ No □ Yes, when:___________________

Treatment type performed: □ Cryotherapy □ LEEP □ Cone Biopsy

40 years of age and older: Date of your last Mammogram ____________________ □ N/A

Have you ever had an abnormal mammogram? □ No □ Yes

Have you ever had breast implants? □ No □ Yes   When: □Current □Past (removed)

Implant Type: □ Silicone □ Saline □ Both types

Do you perform regular breast self examinations? □ No □ Yes

50 years of age or older   Date of your last Colonoscopy _______________________ □N/A

65 years of age or older   Date of your last Dexa/bone scan ____________________ □N/A

Did you fall anytime in the past year? ❑ No ❑ Yes

Do you feel unsteady when standing or walking? ❑ No ❑ Yes

Do you worry about falling? ❑ No ❑ Yes

The American College of Obstetrics and Gynecology (ACOG) recommends Sexually Transmitted Infections testing on sexually active women of all ages. STI testing includes Chlamydia, Gonorrhea, HIV, Syphilis and Hepatitis B.

Would you like testing ordered or performed at your visit*?   No   Yes

*deductible or copay may apply to the laboratory performing the test.

Do you have other concerns you would like to address at this visit?   No   Yes, please list below:

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