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:

_____