WELL WOMEN EXAM QUESTIONNAIRE.

Date:

Name:_____DOB:_____

CurrentMedications:_____

_____

Allergies to Medications:_____

When was your first period?_____years old

When was your last menstrual period? Month: _____ Day: _____ Year:_____

Average number of days between period____ days

Length: _____days Flow: Normal, Heavy, or Light.

Mid Cycle Bleeding: Yes or No

Premenstrual Syndrome: Yes or No

Painful Menstruation: Yes or No; Controlled with Ibuprofen, or Controlled with Birth Control Pills.

History of Abnormal Pap Smear: Yes or No

Daily Calcium Supplement: Yes or No

Sexual Relationship: Yes or No

Number of Life-Time Partners : _____

History of Sexually Transmitted Disease: Yes or No

Sexually Transmitted Disease Prevention: Yes or No

Contraception: None, Birth Control Pills, Condoms, IUD, Tubal Ligation, Vasectomy, Depo-Provera,

Spermicide, Diaphragm, Withdrawal, Natural Family Planning, or Other:_____

Hormone Replacement Therapy: Yes or No

Family history of Breast Cancer: Yes or No

Family history of Ovarian Cancer: Yes or NA

Family history of Uterine Cancer: Yes or No

Family history of Colon Cancer: Yes or No

Total Pregnancies (Number): _____

Full Term (Number):_____ Premature (Number):_____

Abortions (Number):_____ Miscarriages (Number):_____

Ectopics (Number):_____ Multiple Births (Number):_____

Living Children (Number):_____

Pregnancy Complications: Yes or No

Colposcopy: Yes or No

Gynecology Surgeries: None, Hysterectomy, Endometrial Ablation, Tubal Ligation, Vaginal Delivery, Csection, or Other:_____

Post Coital (After Intercourse) Bleeding: Yes or No

Pelvic Pain: Yes or No

Dyspareunia (Painful Intercourse): Yes or No

Gardasil Immunization: Yes or No

Vaginal Discharge: Yes or No

(If Yes, please answer the following questions)

- Color/Consistency: White, Cottage Cheese, Clear, Yellow, or Mucous.

-Pruritus (Itching): Yes or No

-Dysuria (Painful Urination): Yes or No

-Malodorous (Foul Odor): Yes, No, or Worse After Sex.

-Urinary Frequency: Yes or No

-Recent Antibiotic Use: Yes or No

-Treatments Attempted: None, Antifungal, Vagisil.

-After Treatment: Better, Worse, or Same.

If you have children, please answer the following questions about delivery:

Date	Weeks	Labor Hours	Birth Weight	Sex	Delivery Type	Anesthesia	Place of Delivery	Preterm
(2/23/09)	(38)	(12)	(6 lb 4 oz)	(M/F)	(Vaginal/C-section)	(Epi/Spina)l	(Hospital/House)	(Y/N)
_____	_____	_____	_____	____	_____	_____	_____	_____
_____	_____	_____	_____	____	_____	_____	_____	_____
_____	_____	_____	_____	____	_____	_____	_____	_____
_____	_____	_____	_____	____	_____	_____	_____	_____
_____	_____	_____	_____	____	_____	_____	_____	_____
_____	_____	_____	_____	____	_____	_____	_____	_____
_____	_____	_____	_____	____	_____	_____	_____	_____

Signature:

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative **Date**

_____ _____

Please Print Name of Patient, Parent, Guardian or Personal Representative **Relationship to Patient**

_____ _____

Reviewed By **Date**