Annual Well Woman Preventative Exam

Name: _____ DOB:_____ Date:_____

Menstrual History:

Age of first period: _____

First Day of Last Menstrual Periods:_____

☐ None due to: ☐ Uncertain ☐ Birth Control ☐ Pregnant

☐ Hysterectomy without ovaries removed (when: _____)

☐ Hysterectomy with ovaries removed (when: _____)

☐ Menopause (started age: _____)

How many days do your periods last?_____ days

How often do you get your periods? _____ days / weeks / months

The blood flow is: ☐ Light ☐ Medium ☐ Heavy

Do you have any vaginal discharge? ☐ No ☐ Yes

Do you have any concerns or problems with your period?_____

Sexual History:

Are you sexually active? ☐ No ☐ Yes

If no, have you **ever** been sexually active? ☐ No ☐ Yes

Any problems with intercourse?_____

How many sexual partners have you had **within the last year**? _____

What is/are the gender(s) of your sexual partner(s) *(check all that apply)* ?

☐ Male ☐ Female ☐ Transgender ☐ Other: _____

Do you or your partner(s) currently have other sex partners? ☐ No ☐ Yes ☐ Unsure

Have you ever **tested positive** for or been treated for a sexually transmitted disease/infection? ☐ No ☐ Yes

If yes, did you **complete the full course of** treatment? ☐ No ☐ Yes ☐ Unsure

Are you interested in testing for sexually transmitted disease/infection today?

☐ No ☐ Yes

Do you use barrier protection (for example, external or internal condoms) to prevent spread of sexually transmitted disease/infection? ☐ No ☐ Yes

Breast Health:

Do you perform self breast-exams? ☐ No ☐ Yes

If yes, have you noticed any skin changes, nipple changes, breast or armpit lumps?

☐ No ☐ Yes

Do you have a history of breast problems? ☐ No ☐ Yes

if yes, please explain: _____

Contraception:

What is your current method of birth control: _____

Do you want to change your current method? ☐ No ☐Yes

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

Pregnancy History:

Have you ever been pregnant? ☐ No ☐ Yes

If you have been pregnant, please indicate how many:

Pregnancies _____ Miscarriages _____ Abortions _____ Living children _____

Full-term live births _____ Premature births _____

Did you breastfeed any of your children? ☐ No ☐ Yes

When was your last:

Pap Smear (21+ years old): _____

Was HPV co-testing ordered? ☐ No ☐ Yes ☐ Unsure

Have you have had an ABNORMAL pap smear? ☐ No ☐ Yes

if yes, when:_____

Mammogram (40+ years old):_____

Have you ever had an ABNORMAL mammogram? ☐ No ☐ Yes

Do you have a history of breast cancer? ☐ No ☐ Yes

Do you have breast implants? ☐ No ☐ Yes

Colonoscopy (45+ years old): _____

When are you due for your next colonoscopy?_____

Who is your gastroenterologist? _____

Bone Density Scan (65+ years old):_____

Do you a history of low bone mineral density? ☐ No ☐ Yes ☐ Unsure

If you have low bone mineral density, are you currently receiving treatment for it?

☐ No ☐ Yes

Do you anticipating any dental extractions or implants in the next 6-12 months?

☐ No ☐ Yes

Social History:

Are you: ☐Single ☐ Married ☐ Partnered ☐ Divorced ☐ Separated ☐ Widowed

Who do you live with? _____

Do you feel safe in your current living situation? ☐ No ☐ Yes

Have you been a victim of abuse or domestic abuse? ☐ No ☐ Yes

Have you been a victim of human trafficking? ☐ No ☐ Yes

Do you smoke? ☐Never smoked ☐ Quit ☐ Yes

Type: ☐ Cigarettes ☐ E-cigarettes For how long:_____

Do you use smokeless tobacco? ☐ No ☐ Yes

Do you drink alcohol? ☐ No ☐ Yes

If yes, _____ standard drinks per ☐day ☐week ☐month

Do you use any recreational drug(s)? ☐ No ☐ Yes

If yes, which type(s): _____

How frequently: ☐daily ☐weekly ☐monthly ☐less than monthly

Date of last use: _____

Is there any family history of:

Breast cancer? ☐ No ☐ Yes

if yes, who (relationship to you, age of onset): _____

Ovarian cancer?☐ No ☐ Yes

if yes, who (relationship to you, age of onset): _____

Uterine cancer? ☐ No ☐ Yes

if yes, who (relationship to you, age of onset): _____

Prostate cancer? ☐ No ☐ Yes

if yes, who (relationship to you, age of onset): _____

Colon cancer? ☐ No ☐ Yes

if yes, who (relationship to you, age of onset): _____

Other cancers? ☐ No ☐ Yes

if yes, who (relationship to you, age of onset): _____

Osteoporosis? ☐ No ☐ Yes

if yes, who (relationship to you, age of onset): _____

---------- **For Clinic Use Below** ----------

Weight _____ BMI: _____ Blood Pressure _____/_____

Orders: ☐ Pap Smear ☐ + HPV Co-Test ☐ GC/CT ☐ HIV/RPR Serology ☐ Vaginitis Swab

☐ Mammogram ☐ Colonoscopy ☐ Cologuard ☐ iFOBT kit ☐ DEXA (axial)

☐ Other: _____

Return for pap/well woman: ☐ 1 year ☐ 3 years ☐ Other: _____