



WELL-WOMAN EXAM

To help your doctor during today's health exam, please complete items 1 through 11.

1. Date: \_\_\_\_\_ Age: \_\_\_\_\_
First day of last menstrual period (or first year of menstruation, if through menopause): \_\_\_\_\_

2. Number of times pregnant: \_\_\_\_\_
Number of completed pregnancies: \_\_\_\_\_
Date of last pregnancy: \_\_\_\_\_
If you are under age 55, what method of birth control do you use? \_\_\_\_\_
If pills, what kind? \_\_\_\_\_
How many years have you used the pills? \_\_\_\_\_

Are you planning a pregnancy in the next 6-12 months? [ ] YES [ ] NO

3. If you are through menopause or over age 50, do you take any of the following pills?
Calcium [ ] YES [ ] NO
Estrogen (Premarin) [ ] YES [ ] NO
Progesterone (Provera) [ ] YES [ ] NO

4. Have you had any of the following problems:
a. Abnormal Pap smears [ ] YES [ ] NO
If yes, date: \_\_\_\_\_ problem: \_\_\_\_\_
For abnormality, did you have any of the following done:
Colposcopy [ ] YES [ ] NO
Biopsies [ ] YES [ ] NO
Surgery [ ] YES [ ] NO

b. High blood pressure, heart disease or high cholesterol [ ] YES [ ] NO

c. Migraine headaches, blood clot in legs or cancer [ ] YES [ ] NO

d. Abdominal or pelvic surgery or special tests [ ] YES [ ] NO
If yes, what: \_\_\_\_\_ when: \_\_\_\_\_

5. Do you have any of the following:
a. Problems with present method of birth control [ ] YES [ ] NO

b. Bleeding between periods or since periods stopped [ ] YES [ ] NO

c. Pain with intercourse or periods [ ] YES [ ] NO

d. Any problem with interest in or enjoying intercourse [ ] YES [ ] NO

e. A new or enlarging lump in breast [ ] YES [ ] NO

f. Change in size/firmness of stools [ ] YES [ ] NO

g. Change in size/color of a mole [ ] YES [ ] NO

h. Severe headaches [ ] YES [ ] NO

i. Pain in the leg, chest, abdomen or joints [ ] YES [ ] NO

j. Trouble falling or staying asleep [ ] YES [ ] NO

k. Often feeling down, depressed or hopeless during the past month [ ] YES [ ] NO

l. Often having little interest or pleasure in doing things during the past month [ ] YES [ ] NO

m. Conflict in your family or relationships, sometimes handled by pushing, hitting or cruelty [ ] YES [ ] NO

6. Review of Systems o All systems neg. except as marked
Constitution Geniurinary
[ ] Fever [ ] Urination problems
[ ] Chills [ ] Frequent Urination
[ ] Fatigue [ ] \_\_\_\_\_
[ ] Weight loss/gain \_\_\_\_\_ Female GU
[ ] \_\_\_\_\_ [ ] LMP \_\_\_\_\_
ENT/Eyes [ ] Postmenopausal/hysterectomy
[ ] Nasal/Sinus drainage [ ] Abnormal bleeding/discharge
[ ] Visual disturbances [ ] \_\_\_\_\_
[ ] Sore Throat [ ] \_\_\_\_\_
[ ] \_\_\_\_\_ Skin/MS
Pulmonary/CVS [ ] Skin rash
[ ] Cough [ ] Back pain
[ ] Trouble breathing [ ] Leg swelling
[ ] Chest pain [ ] \_\_\_\_\_
[ ] \_\_\_\_\_ Neuro/Psych
Gastrointestinal [ ] Headache
[ ] Abdominal pain [ ] Blackout
[ ] \_\_\_\_\_ [ ] Loss of feeling/power arm leg face R / L
[ ] Nausea/vomiting [ ] Anxiety / Depression
[ ] \_\_\_\_\_ [ ] \_\_\_\_\_
[ ] \_\_\_\_\_ [ ] \_\_\_\_\_

Name: \_\_\_\_\_
DOB: \_\_\_\_\_



# Saint Alphonse Medical Group

7. Do you have a parent, brother or sister with a history of the following:

- a. Cancer of the breast, intestine or female organs  YES  NO
- b. Heart pain or heart attacks before the age of 55  YES  NO

If yes to a or b:

Relation: \_\_\_\_\_ Type: \_\_\_\_\_  
Relation: \_\_\_\_\_ Type: \_\_\_\_\_

8. Osteoporosis (thin-bone) screening:

- a. Is there a history of any relatives with the following: stooping over or losing height as they got older, "thin bones," hip fractures  YES  NO  
If yes, relation: \_\_\_\_\_

b. Have you had any of the following:

- Height loss  YES  NO
- Broken hip or wrist  YES  NO
- Bone-density test  YES  NO
- Have you ever had any abnormal mammograms?  N/A  YES  NO

If yes, date: \_\_\_\_\_ problem: \_\_\_\_\_

For abnormality, did you have any of the following:

- Biopsy  YES  NO
- Cyst fluid drained  YES  NO
- Surgery  YES  NO

c. Do you take any of the following:

- Steroids (prednisone)  YES  NO
- Medication for thyroid, seizures or thin bones  YES  NO

9. Have you ever used tobacco?  YES  NO

If yes:

Average number of packs/day: \_\_\_\_\_

Number of years smoked: \_\_\_\_\_

Year quit: \_\_\_\_\_

When are you planning to quit?

- now  next 6 months  sometime  never

10. Do you drink alcohol?  YES  NO

If yes:

a. Have you ever felt you should cut down on your drinking?  YES  NO

b. Have people ever annoyed you by nagging you about your drinking?  YES  NO

c. Have you ever felt guilty about your drinking?  YES  NO

d. Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover?  YES  NO

11. Prevention:

a. \_\_\_\_\_

b. Exercise:

Activity \_\_\_\_\_

Days per week \_\_\_\_\_

Time/duration \_\_\_\_\_ minutes

Exertion:  stroll  mild  heavy

c. Do you always wear seat belts?  YES  NO

d. If over 30 years old, have you had your cholesterol level checked in the past five years?  YES  NO

e. Have you had a tetanus shot in the past 10 years?  YES  NO

f. Does your house have a working smoke detector?  YES  NO

g. Do you have firearms at home?  YES  NO

h. Have you ever had a mammogram?  YES  NO  
If yes, date of last: \_\_\_\_\_ where: \_\_\_\_\_

i. How many sexual partners have you had in the last 12 months? \_\_\_\_\_  
In your lifetime? \_\_\_\_\_

j. When is the last time you had a dental check-up? \_\_\_\_\_

12. Please describe any concerns you have:

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*Thank you for your help.*

Name: \_\_\_\_\_

DOB: \_\_\_\_\_