Women's Health Questionnaire

Today's Date: ______/__________/__________

Name: ____________________________________ Birth Date: _______/________/_________

Who is your family doctor: ____

Allergies: (food, medication, other): ____

How many times have you been pregnant? _________ How many children do you have? ______

Have you ever had any miscarriages or abortions? ____

Date of last Pap test: _________________________

Have you ever had an abnormal pap test? Y N Details: ____

Date of last mammogram? ____________ Have you ever had an abnormal mammogram? Y N

First day of last menstrual period: ______________ What age did you start your periods? ___________

How long do your periods last? _______________ How far apart are your periods? _______________

Do you feel that your periods are normal? Y N

If no, explain: ____

Do you experience any pain? If yes, when? ____

Are you currently sexually active? Y N Any new sexual partners in the last year? Y N

Do you want to add anything about sexual preference? men women or both

Are you using any type of Birth Control? Y N

If yes, what type? (pill, condom, withdrawal, etc) _____________________________

Have you ever had a Sexually Transmitted Infection?

Herpes [ ] Chlamydia [ ] Gonorrhea [ ] Genital Warts[ ]

Cervical Cancer [ ] Pelvic Inflammatory Disease [ ]

Date of last bone density test: (Age 65 +) _____________________ Results: ______________

Date of last colonoscopy (50+): _____________________________ Results: ______________

Are you having any problems today? ____

____

How long has this been going on? ____

Is it getting better/worse/staying the same? ____

Does anything seem to help it or make it feel worse? ____

Have you tried anything to treat it yet? ____