

# Women's Health Visit

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

Date: \_\_\_\_\_

**First day** of last menstrual period? \_\_\_\_\_  No periods

Number of pregnancies total: \_\_\_\_\_ Full-term births: \_\_\_\_\_ Premature births: \_\_\_\_\_ Abortions: \_\_\_\_\_ Miscarriages: \_\_\_\_\_  
Living children: \_\_\_\_\_

Your age when you had your first period? \_\_\_\_\_  Never had period

How often do you usually get your period? every \_\_\_\_\_ days

Are your periods usually regular?  Yes  No How many days do your periods usually last? \_\_\_\_\_ days

The blood flow is:  Light  Moderate  Heavy Do you have any bleeding/spotting between periods?  Yes  No

Do you have any abnormal vaginal discharge?  Yes  No Vaginal odor?  Yes  No Vaginal Itching?  Yes  No

Are you sexually active?  Yes  No

Have you ever had a sexually transmitted infection?  Yes  No List: \_\_\_\_\_

When was your last PAP test?  1 yr  2 yrs  >3yrs  Never Were the results normal?  Yes  No  Unsure

Have you ever had an **abnormal** PAP test or been told you have HPV?  Yes  No

Have you received the Gardasil vaccination series?  Yes  No If no, are you interested in vaccination?  Yes  No

What form of birth control do you use?  None

Condoms

Patch

DepoProvera

Pill

Implanon

Tubal Ligation

Mirena/Paragard

Total Hysterectomy

NuvaRing

Partial Hysterectomy; do you still have a cervix and/or ovaries?  Yes  No

On a scale of 0 to 10, with 0 being no symptoms and 10 being severe symptoms, how would you describe the following (please circle):

Pain during your usual period: 0 1 2 3 4 5 6 7 8 9 10

Pain during sex: 0 1 2 3 4 5 6 7 8 9 10

PMS (premenstrual syndrome): 0 1 2 3 4 5 6 7 8 9 10

Do you smoke?  Yes  No If yes, how much per day? \_\_\_\_\_

How often do you perform self breast-exams?  Monthly  Occasionally  Rarely  Never

Do you have a history of breast problems?  Yes, \_\_\_\_\_  No

Have you ever been abused?  Yes  No

Do you feel safe?  Yes  No

Is there any **family history** of:

Breast cancer?  Yes  No

Colon cancer?  Yes  No

Uterine cancer?  Yes  No

Ovarian cancer?  Yes  No

Osteoporosis?  Yes  No

Heart disease?  Yes  No

Have you ever had a mammogram?  Yes, when \_\_\_\_\_  No

Have you ever had a bone density test?  Yes, when \_\_\_\_\_  No

Have you had a colonoscopy?  Yes, when \_\_\_\_\_  No

Age you reached menopause? \_\_\_\_\_ Do you have hot flashes?  Yes  No Night sweats?  Yes  No

Are you on hormone replacement?  Yes, name of hormone \_\_\_\_\_  No