Cascade FAMILY MEDICINE

Central Utah Clinic PC
Your Health, Your Choice.™

Name:_____
Date of Birth:_____

WELL – WOMAN EXAM

To help your doctor during today's health exam, please complete items 1 through 13.

Today's Date: _____

1. 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 pill?_____
   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/color 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. 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: _____

7. Osteoporosis (thin-bone) screening:
   a. Is there a history of any relatives with the following: stooping over or losing height as they get older, "thin bones", hip fractures ☐ Yes ☐ No
      If yes, relation:_____
   b. Have you had any of the following:
      - Hair loss ☐ Yes ☐ No
      - Broken hip or wrist ☐ Yes ☐ No
      - Bone-density test ☐ Yes ☐ No

   c. Do you take any of the following:
      - Steroids (Prednisone) ☐ Yes ☐ No
      - Medication for thyroid, seizures, or thin bones ☐ Yes ☐ No

8. Have you ever used tobacco? ☐ Yes ☐ No
   If yes:
   Average number of packs per day: _____
   Number of years you smoked: _____
   Year quit: _____
   When are you planning to quit?
   ☐ now ☐ next 6 months ☐ sometime ☐ never

9. 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

10. Prevention:

a. Which of the following are included in your diet:

Grains and starches	☐ a lot	☐ some	☐ few
Vegetables	☐ a lot	☐ some	☐ few
Dairy foods	☐ a lot	☐ some	☐ few
Meats	☐ a lot	☐ some	☐ few
Sweets	☐ a lot	☐ some	☐ few

b. Exercise:

Activity:_____

Days per week:_____

Time/duration:_____minutes

Exertions: ☐ 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:_____

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

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?_____

11. Surgery: ☐ Yes ☐ No

List Surgeries:

_____

_____

_____

_____

_____

12. Please describe any concerns you have:

_____

_____

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_____

_____

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_____

13. Please list the current medications you are taking:

_____

_____

_____

_____

_____

_____

Thank you for your help