WELL-WOMAN EXAM

To help your midwife during today's health exam, please complete items 1 through 12.

1. Age: _____

   First day of last menstrual period (or first year without 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, were 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. Lack of interest in intercourse or lack of enjoyment? ☐ 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 ☐ 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 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

   c. Diabetes ☐ Yes ☐ No
      If yes to a, b or c:
      Relation: _____ Type: _____
      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 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

- Patient Label -

8. Have you ever used tobacco? ☐ Yes ☐ No

If yes:
Average number of packs/day: _____
Number of years smoked: _____
Year that you quit: _____

When are you planning to quit?
☐ now ☐ next 6 months ☐ sometime ☐ never

9. Do you drink alcohol or use street drugs? ☐ Yes ☐ No

If yes:
a. How often? _____

b. Which drugs? _____

c. Have people ever annoyed you by nagging you about your drinking? ☐ Yes ☐ No

d. Have you ever felt guilty about your drinking or drug use? ☐ Yes ☐ No

10. Do you take any medications or herbs? ☐ Yes ☐ No
Please list: _____
_____

11. 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 _____ 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
If over 30, have you had your HPV checked? ☐ 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? ☐ 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? _____

Your sexual orientation: _____

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.

- Patient Label -