

**PERIODIC WOMEN'S HEALTH ASSESSMENT**

Please fill out this questionnaire as completely as possible. The information provided will become part of your medical record and is totally confidential. This information will assist us in our effort to provide quality health care.

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
(Last) (First) (Middle Initial)

DOB: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Occupation: \_\_\_\_\_

**Please note the reason for you visit here today:** \_\_\_\_\_

**ALLERGIES:**

**Please note any allergies or reactions to medications or other agents.**  None

Medication: \_\_\_\_\_ Reaction: \_\_\_\_\_

Medication: \_\_\_\_\_ Reaction: \_\_\_\_\_

Medication: \_\_\_\_\_ Reaction: \_\_\_\_\_

**CURRENT PRESCRIPTION MEDICATIONS:**

Please list PRESCRIPTION medications you currently take including DOSAGE AND INSTRUCTIONS.  None

Med/Dose/Instr: \_\_\_\_\_

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Med/Dose/Instr: \_\_\_\_\_

Med/Dose/Instr: \_\_\_\_\_

Please list any non-prescription medications, supplements and/or herbal remedies you take: \_\_\_\_\_

**CURRENT HEALTH STATUS:**

Date your last period began: \_\_\_\_\_ Was it normal?  no  yes

How often do you have periods: \_\_\_\_\_ How many days do your periods last? \_\_\_\_\_

Flow:  light  average  heavy Do you have spotting or bleeding between periods?  no  yes

If post-menopausal, are you experiencing any vaginal bleeding?  no  yes

Have you ever been on Hormone Replacement Therapy?  no  yes

If so for how long? \_\_\_\_\_

**GYNECOLOGIC HISTORY:**

**Check if you have had any of the following:**  None

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> ovarian cyst       | <input type="checkbox"/> endometriosis              | <input type="checkbox"/> abnormal Pap          |
| <input type="checkbox"/> polycystic ovaries | <input type="checkbox"/> abnormal uterine structure | <input type="checkbox"/> DES exposure in utero |
| <input type="checkbox"/> fibroid uterus     | <input type="checkbox"/> infertility                | <input type="checkbox"/> other _____           |

**Have you been vaccinated against the HPV virus?**  no  yes  don't know

**MEDICAL/SURGICAL HISTORY:**

Since your last exam here, have you had any major health problems or surgery?  no  yes

If yes, explain: \_\_\_\_\_

**FAMILY HISTORY:** Please note any changes in the health of your family since your last visit:  None

**LIFESTYLE:**

Do you currently smoke cigarettes?  no, never  have exposure to second hand smoke  
 yes Date Started: \_\_\_\_\_ Amt/PPD: \_\_\_\_\_  
 quit Date Started: \_\_\_\_\_ Amt/PPD: \_\_\_\_\_ Date Stopped: \_\_\_\_\_

How many alcoholic drinks do you have in an average week?  none  # \_\_\_\_\_

What recreational drugs are you currently using, if any?  none \_\_\_\_\_

**SEXUAL HISTORY:**

Are you currently sexually active?  no  yes Are your partner(s)  male  female  
Do you or your partner have more than one partner?  no  yes  I don't know  
Do you want to be screened for any sexually transmitted infections?  no  yes  unsure  
Do you want to be screened for HIV, the virus that causes AIDS?  no  yes  unsure  
What method of birth control, if any, are you using? \_\_\_\_\_  
Are you planning a pregnancy in the next year?  no  yes

**OTHER ACTIVITIES:**

How often do you exercise?  regularly  occasionally  rarely  never  
What: \_\_\_\_\_

Do you use a seatbelt?  no  yes  
Do you have any concerns about weight?  none  gain  loss  
Do you take a calcium supplement?  no  yes  
Have you been emotionally or physically abused by your partner or someone close to you?  no  yes

**REVIEW OF SYSTEMS:** Check if you *currently* have *problems* with:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> fatigue                    | <input type="checkbox"/> persistent cough           | <input type="checkbox"/> fainting/dizziness/balance |
| <input type="checkbox"/> weight loss                | <input type="checkbox"/> shortness of breath        | <input type="checkbox"/> anxiety                    |
| <input type="checkbox"/> weight gain                | <input type="checkbox"/> wheezing                   | <input type="checkbox"/> depression                 |
| <input type="checkbox"/> easy bruising              | <input type="checkbox"/> difficulty breathing       | <input type="checkbox"/> memory loss                |
| <input type="checkbox"/> enlarged glands or lumps   | <input type="checkbox"/> indigestion or nausea      | <input type="checkbox"/> trouble sleeping           |
| <input type="checkbox"/> environmental allergies    | <input type="checkbox"/> abdominal pain or bloating | <input type="checkbox"/> varicose veins             |
| <input type="checkbox"/> hot flashes                | <input type="checkbox"/> constipation               | <input type="checkbox"/> muscle or joint pain       |
| <input type="checkbox"/> heat or cold intolerance   | <input type="checkbox"/> diarrhea                   | <input type="checkbox"/> back pain                  |
| <input type="checkbox"/> excess hair growth or loss | <input type="checkbox"/> painful urination          | <input type="checkbox"/> breast pain                |
| <input type="checkbox"/> skin                       | <input type="checkbox"/> involuntary loss of urine  | <input type="checkbox"/> breast discharge           |
| <input type="checkbox"/> moles                      | <input type="checkbox"/> abnormal vaginal discharge | <input type="checkbox"/> breast lump                |
| <input type="checkbox"/> chest pain                 | <input type="checkbox"/> headaches                  | Other _____   |

Date of last mammogram: \_\_\_\_\_ Date of last Colonoscopy: \_\_\_\_\_

Primary Care Provider \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_

If you would like a copy of today's visit sent to your PCP or another clinician please sign below & provide the name and address of the clinician if it is not your PCP.

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