Well Woman Exam

Center for Integrative Health

Date: **Name:** **Age:** **Date of Birth:**

Last **First** **M.I.** **(Preferred)**

Marital Status (please circle): Single Married Separated Divorced Widowed

Occupation:

What is the main reason you came in today?

Date of Last Period_____. Number of days from 1st day of your period to the 1st day of the next period____

YES NO

☐ ☐ Missed any periods? If so, how many?_____

☐ ☐ Had periods less than 24 days apart?_____

☐ ☐ Had excessively heavy periods_____

☐ ☐ Experienced bleeding in between periods?_____

☐ ☐ Had extreme moodiness, headaches and /or bloating before periods that resolve at the onset of the period? If yes, what have you tried to help your symptoms?_____

Past Personal Medical History-In the Past 6 Months

☐ ☐ Do you use douches? How often?_____Type?_____

☐ ☐ Have you used any over-the-counter anti-yeast products? How often?_____

☐ ☐ Do you have frequent abnormal or foul-smelling vaginal discharge?_____

☐ ☐ Do you apply talcum powder to the female area on a daily basis?(discouraged?)_____

☐ ☐ Does bleeding occur after sex when you are not due for your period?

☐ ☐ Have you ever had sexual intercourse?
List the approximate date of your last sexual intercourse_____

☐ ☐ Have you ever been pregnant? # Full-Term Pregnancies?___ # Miscarriages?___
#Premature births?___ # Abortions?___

☐ ☐ Have you ever had any of the following?
☐ Genital herpes ☐ Gonorrhea ☐ Syphilis ☐ Chlamydia ☐ Venereal Warts (HPV or Condyloma)
☐ Pelvic Indlamamatory disease requiring antibiotics in the muscle or vein
☐ HIV ☐ Hepatitis

Cervical History Date of last Pap Smear?_____ Results: ☐ Normal ☐ Abnormal ☐ Don't Know

☐ ☐ Have you had a previous abnormal pap smear?
Date_____ How was it evaluated?_____By whom?_____

Breast History

☐ ☐ Do you do monthly breast self-exams? Are you comfortable with your exam?_____

☐ ☐ Have you ever had a mammogram? Give date_____ Location_____
Results: ☐ Normal ☐ Abnormal-Explain_____

Immunization Diary- Indicate date of last shot.

Flu:	Measles:	Tetanus:	
Hepatitis B:	Pneumovax:	Guardasil #1 #2 #3	
Tuberculosis(TB) Skin Test:	Results:	Other Vaccines:	

Family History: Has your mother, father, brother or sister had any of the following: ☐ Diabetes ☐ Heart Disease

YES NO If response is YES, please explain.

☐ ☐ Do you feel your weight is optimal? What do you think you should weigh?_____ How tall are you? ____

☐ ☐ Has your cholesterol level been checked in the last 3years?
Results: ☐ Normal ☐ Abnormal- Explain_____

What else concerns you about your health?_____

What one issue specifically concerns you the most about your health?_____

Patient Signature:_____ **Date**:_____ Reviewed By:_____

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-Dwana Bush M.D.-