



place label here

Name: _____

UIN: _____

Date: _____

Women's Health Patient Questionnaire

A. MENSTRUAL HISTORY

Age of first period _____

Periods usually come every _____ days.

Periods usually last for _____ days.

Was the last menstrual period normal in length and flow:
 Yes No

Do you have cramps with your period? Yes No

Do you take any medication for menstrual pain? Yes No
If yes, what _____

Does your pain interfere with work or class? Yes No

Number of pads/tampons used on heaviest day: _____

Do you have bleeding between your periods? Yes No

B. CONTRACEPTIVE HISTORY

Not applicable (*move to next section*)

Have you used any of the following? (*Check all that apply*)

Abstinence

Barrier method: Condoms 100% Diaphragm

Hormonal: Pills Shot Implant Ring Patch

IUD: Skyla Mirena ParaGard

Spermicide

Emergency contraception

Other _____

What is your current method of birth control? _____

Have you had sex without using any birth control method since your last menstrual period? Yes – date _____ No

C. SEXUAL HISTORY

Have you engaged in sexual contact (oral, vaginal, anal) with:
 men women both neither

At what age did you become sexually active? _____

How many partners in the last 12 months? _____

Do you have a current sexual partner? Yes No
How long have you been with your current sexual partner? _____

Have you ever been diagnosed with or treated for any of the following sexually transmitted diseases? (*check all that apply*)

None

chlamydia genital herpes oral herpes

genital warts hepatitis syphilis gonorrhea

Other _____

How do you protect yourself against STDs? (*check all that apply*)

abstinence oral barriers condoms

long-term monogamy STD testing for self

STD testing of contact/partner

Other _____

Have you ever experienced any unwanted sexual contact as a child or an adult? Yes No

Have you ever had concerns about physical or emotional violence in a relationship? Yes No

D. GYNECOLOGIC RELATED HISTORY

Have you ever had a pelvic exam? Yes No

Have you ever had an **abnormal** Pap smear? Yes No

Have you completed the HPV vaccine series (Gardasil)?
 Yes No Comments _____

Have you ever had any of the following?

Breast abnormalities

Abnormal amount of hair growth (facial, chest, abdomen)

Endometriosis

Ovarian cysts

Fibroids

Pelvic Inflammatory Disease

E. PREGNANCY HISTORY

Have you ever been pregnant? Yes No

If yes, what was the outcome?

Birth # _____ date _____

Termination # _____ date _____

Miscarriage # _____ date _____

Tubal pregnancy # _____ date _____

Complications/comments _____

Clinician Comments: _____

place label here

Name: _____
UIN: _____
Date: _____

Women's Health Patient Questionnaire (continued)

F. PATIENT MEDICAL HISTORY

Have you ever been diagnosed with or treated for any of the following:

	Yes	No		Yes	No		Yes	No
Acne	<input type="checkbox"/>	<input type="checkbox"/>	Migraines	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Severe Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Heart Abnormalities	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Eating Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Mono in the last 6 months	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease/Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Urinary Tract Infections	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Blood Clots in legs, lung, brain	<input type="checkbox"/>	<input type="checkbox"/>	#_____in past year		
Seizure/Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Inflammation of leg veins	<input type="checkbox"/>	<input type="checkbox"/>	Other_____		

List past surgeries/hospitalizations _____

G. FAMILY HISTORY

Were you adopted? Yes No

Indicate below any family member (parents, grandparents, siblings, children) with any of the following:

	Yes	No	Family member / age diagnosed:		Yes	No	Family member / age diagnosed:
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____	Breast Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	_____	Ovarian Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>	_____	Uterine Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Elevated Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	_____	Colon Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	Other_____			
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____				

H. HEALTH HABITS / WELLNESS HISTORY

Do you use tobacco products? Yes No If yes, how many per day? _____

Do you sometimes drink beer, wine or other alcoholic beverages? Yes No
If yes, how many times in the past year have you had 4 or more drinks in a day? _____

How many times in the past year have you used an illegal drug or used a prescription medication for nonmedical reasons? _____

Do you text while driving? Yes No

Do you wear a helmet when riding a bike or motorcycle and/or while rollerblading or skateboarding? Yes No N/A

Do you exercise routinely? Yes No If yes, how often? _____

What is your selected food pattern? All food groups Vegetarian Lacto-ovo-vegetarian Vegan Other _____

Patient Signature _____

Date _____

Clinician Comments: _____

Clinician Signature _____

Date _____