



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 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

Abnormal Pap Smear _____

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 _____