OLYMPUS FAMILY MEDICINE

Well-Woman Exam Questionnaire

PATIENT INFORMATION

FULL NAME: _____ DATE OF BIRTH: ____/____/_____
LAST FIRST MI MM DD YYYY

Circle your responses to the following questions. This will help your provider identify possible areas of concern.

Have you ever had a PAP in the past? YES NO

If yes, date of last PAP: 1 yr 2 yrs >3 yrs

Were the results of your last PAP normal? YES NO

Have you ever had an abnormal PAP Result? YES NO

When was the first day of your last menstrual period?

_____

Are your periods usually regular? YES NO

How often do you get your periods? Every _____ days

The blood flow is usually: LIGHT MODERATE HEAVY

How many days does your period last? _____days

Are you currently sexually active? YES NO

Do you use birth control? YES NO

Method: _____

Do you usually experience pain during sex?

NONE MILD MODERATE SEVERE

Do you have any vaginal discharge? YES NO

Have you been diagnosed with PMS? YES NO
(Premenstrual Syndrome)

Have you ever had a sexually transmitted disease? YES NO

If yes, what: _____

Do you experience hot flashes? YES NO

Are you using hormone replacement therapy? YES NO

Have you used fertility methods in the past? YES NO

Have you had a hysterectomy? YES NO

If yes, was it: PARTIAL *or* TOTAL

Do you have PMS (premenstrual tension syndrome)?

NONE MILD MODERATE SEVERE

When was your last mammogram? _____

How often do you perform self breast-exams?

MONTHLY OCCASIONALY RARELY NEVER

Have you ever been physically or sexually abused?

YES NO

If you have been pregnant, please indicate how many apply:

___ Total Pregnancies ___ Full-Term Births ___ Pre-Term Births ___ Abortions (elective or spontaneous) ___ # of Living Children

Do you have any know family history of the following conditions:

Breast Cancer:	YES	NO	Colon Cancer:	YES	NO
Uterine Cancer:	YES	NO	Other Cancers:	YES	NO
Osteoporosis:	YES	NO	Heart Disease:	YES	NO

Please list any other concerns: _____

_____

_____

Patient Signature: _____ Date: _____

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