

Women's Preventive Screening Questionnaire

| | | | |
|--|--|----------------|--|
| Name: | | Date of Birth | |
| Home Address: | | | |
| Primary Phone: | | E-mail address | |
| Emergency Contact Name and phone #: | | Relationship | |
| Primary health care provider: | | | |

Gynecologic/Endocrine History

| | | | | | |
|-------------------------------|--|---|-----------|------------|-----------|
| Date of last menstrual period | | Was it normal? | Yes ___ | No ___ | |
| Age of first menses | | Days between menses (from first day to first day) | | | |
| Length of flow | | Amount of Flow: | Heavy ___ | Medium ___ | Light ___ |

Do you have any of the following symptoms? (Check box to right of symptom)

| | | | | | | | |
|-------------------------------|--|----------------------------|--|------------------------------|--|---------------------------|--|
| Premenstrual discomfort | | Abnormal vaginal discharge | | Blood clots in legs or lungs | | Fever, chills, or sweats | |
| Premenstrual mood disturbance | | Abdominal pain | | Low sexual interest | | Dry skin or Brittle nails | |
| Heavy menses | | Pain with urination | | Pain with intercourse | | Excess body hair | |
| Bleeding between periods | | Bladder control problems | | Difficulty with orgasm | | New moles or rashes | |
| Bad menstrual cramps | | Fatigue | | Teeth grinding | | Hair loss | |
| Breast pain | | Weight gain | | Memory disturbance | | Acne | |
| Genital pain | | Weight loss | | Depression or anxiety | | Body aches | |

Current form of Contraception (if applicable)

| | | | | | |
|----------------|---------------|------------|----------------|---------------|---------------|
| Abstinence ___ | IUD ___ | Pills ___ | Shot ___ | Patch ___ | Implant ___ |
| Condoms ___ | Diaphragm ___ | Rhythm ___ | Tubes tied ___ | Vasectomy ___ | Menopause ___ |

Preventive Screening History

| | | | | |
|--|--------------------|-------------|--------------------|-----------------|
| Date of last pap | → | Result: → | Normal ____ | Abnormal ____ |
| Ever had abnormal pap? | Yes ____ No ____ | | | |
| Ever treated for cervical dysplasia? | Yes ____ No ____ | | | |
| Ever treated for sexually transmitted infection? | Yes ____ No ____ | | | |
| Ever treated for uterine infection? | Yes ____ No ____ | | | |
| Cholesterol level | Never checked ____ | Normal ____ | A little high ____ | Quite high ____ |
| Triglyceride level | Never checked ____ | Normal ____ | A little high ____ | Quite high ____ |
| If over 40 date of last mammogram | | Result: | Normal ____ | Abnormal ____ |
| If over 50 date of last colonoscopy | | Result: | Normal ____ | Abnormal ____ |

Lifestyle and Habits

| | | | | |
|---|-------------------|------------------------------|--------------------------|---------------|
| Do you use tobacco? | Yes ____ No ____ | How much? | | |
| Do you drink alcohol? | Yes ____ No ____ | How much? | | |
| Do you use recreational drugs? | Yes ____ No ____ | What kind? | | |
| Are you on any special diet? | Vegetarian ____ | Low Carb ____ | Low fat ____ | Low Cal ____ |
| Exercise per week: | None ____ | 1-3 hours ____ | 4-6 hours ____ | >6 hours ____ |
| Type(s) of exercise: | | | | |
| General mental stress level: | Low stress ____ | Moderate stress ____ | High stress ____ | |
| Current Occupation(s): | | | | |
| Relationships | | | | |
| How long have you been with your current partner? | | Number of previous partners: | | |
| Sexual preference: | Heterosexual ____ | Bisexual ____ | Lesbian ____ | Asexual ____ |
| Do you feel safe in your current relationship? | Always ____ | Usually ____ | Rarely ____ | Never ____ |
| Have you or your partner(s) ever used IV drugs? | Yes ____ | No ____ | Don't know for sure ____ | |

Family History: Mark box to right if any history in first or second degree blood relatives of:

| | | | | | |
|------------------------------|--------------------------|----------------|--------------------------|----------------|--------------------------|
| Blood clots to legs or lungs | <input type="checkbox"/> | Liver problems | <input type="checkbox"/> | Kidney disease | <input type="checkbox"/> |
| Cancer | <input type="checkbox"/> | Dementia | <input type="checkbox"/> | Heart disease | <input type="checkbox"/> |
| Diabetes | <input type="checkbox"/> | Depression | <input type="checkbox"/> | Hypertension | <input type="checkbox"/> |
| Arthritis | <input type="checkbox"/> | Stroke | <input type="checkbox"/> | Seizures | <input type="checkbox"/> |

Patient signature: _____ **Date:** _____

Reviewed by: _____ **Date:** _____