Flathead Valley Community College™

Student Health Clinic

Name_____ **Date of Birth**_____

Well Woman Exam Questionnaire

Are you concerned about any of the following? (circle yes or no and specific problem)

Eating habits: weight gain or loss, sleep habits……yes no
Eye redness, pain, increased tearing, drainage, blurred, decreased vision …… yes no
Ear pain, decreased hearing …… yes no
Heart problems, chest pain, palpitations, blood pressure, leg swelling ……yes no
Lung problems, difficulty breathing, wheezing, cough …… yes no
Abdominal pain, nausea, vomiting, diarrhea, constipation, bloody stool ……yes no
Kidney or bladder problems, infection, blood in urine …… yes no
Joint pain, stiffness, swelling, muscles pain or weakness …… yes no
Skin, rash, itching, dryness, hair or nail problems ……yes no
Recurrent headaches, dizziness, numbness, weakness ……yes no
Stress, anxiety, sadness, depression, suicidal thoughts …… yes no
Excessive thirst or hunger, increased urination, weight loss ……yes no
Paleness, anemia, easy bruising, swollen glands …… yes no
Allergies, hay fever, asthma, infections …… yes no

Comments_____
_____

Personal History

Are you concerned about any of the following? (circle yes or no)

Menstruation ……yes no
Pain or bleeding with intercourse ……yes no
Vaginal itching or discharge……yes no
Sexually transmitted diseases, AIDS, other sexual concerns ……yes no

Comments_____
_____

Do you have menstrual periods? …… yes no
Date of last menstrual period _____
Have you ever had a PAP smear? ……yes no
Date of last PAP smear _____ Was it normal? ……yes no
Have you ever had a mammogram?……yes no
Date of last mammogram_____Was it normal?……yes no
Are you sexually active? ……yes no
If you are sexually active, do you use birth control?……yes no
What method? _____
Have you had more than 4 lifetime partners?……yes no
How many:
Pregnancies_____ Live births _____ miscarriages _____ Abortions _____?

Name_____ **Date of Birth**_____

Social History

Are you: single married divorced widowed ?

Do you feel safe at home, in your relationships with family/partner? ……..yes no

Do you smoke or use tobacco products? ……..yes no

If yes, how many packs/cans per day? _____ How many years? _____

Do you use recreational drugs? ……yes no

If yes, type _____ frequency? _____

Do you drink alcohol? ……...yes no

If yes, how many per day? _____ per week? _____

Do you always use a seat belt in a vehicle? ……..yes no

Preventative Health History

Have you ever had a colonoscopy? ……..yes no

Have you ever had your cholesterol checked?……..yes no

When? _____ Was it normal? ……...yes no

Have you had a tetanus shot in the past 10 years?…… yes no

When? _____

Personal/Family History

Have **<u>you</u>** had any of the following?

Breast cancer	yes	no	when?_____
Uterine cancer	yes	no	when?_____
Ovarian Cancer	yes	no	when?_____
Cervical Cancer	yes	no	when?_____
Colon Cancer	yes	no	when?_____
Osteoporosis	yes	no	when?_____
Heart disease	yes	no	when?_____
Heart attack before age 55	yes	no	when?_____

Have any **<u>close relatives</u>** had any of the following?

Breast Cancer	yes	no	who? _____
Uterine Cancer	yes	no	who? _____
Ovarian Cancer	yes	no	who? _____
Cervical Cancer	yes	no	who? _____
Osteoporosis	yes	no	who? _____
Heart Disease	yes	no	who? _____
Heart attack before the age of 55	yes	no	who? _____

Do you have any concerns you wish to discuss?_____

_____

_____

_____

Patient signature_____**Date**_____