Print Form

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Complete Care Medicine

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WELL WOMAN EXAM QUESTIONNAIRE FORM

Patient Name:_____ DOB: _____Date: _____

Personal/Social History:

Are you: ☐ Single ☐ Married ☐ Partnership ☐ Divorced ☐ Widowed

Do you have Children? ☐ Ye☐ No Ages of child(ren)___

No. of pregnancies _____ Miscarriages _____

PLEASE ENTER YOUR INFORMATION:

1. Concerned about your breasts: changes in size or shape, changes in skin color, lumps, tenderness, discharge or blood from nipple, inverted nipple? ☐ Yes ☐ No
2. Concerned about your menstruation: frequency, amount of flow, cramping, premenstrual tension, menopausal symptoms, postmenopausal bleeding? ☐ Yes ☐ No
3. Do you take hormones (estrogen)? ☐ Yes ☐ No
4. Concerned about: vaginal itching, dryness or discharge, pain or bleeding with intercourse, fertility problems, lack of enjoyment of sex? ☐ Yes ☐ No
5. Concerned about lesions, lumps or swelling on your vulva or vagina? ☐ Yes ☐ No
6. Concerned about: pain on urination, blood in urine, repeated urinary infections, awakening at night to urinate, urine leakage? ☐ Yes ☐ No
7. Concerned about: Abdominal Pain, constipation or diarrhea, laxative or antacid use, rectal pain or bleeding, hemorrhoids? ☐ Yes ☐ No
8. Avg. length of menstrual cycle (i.e. 26-30 days) _____
9. Avg. duration of menstruation: _____
10. Approx. Date of last menstruation:_____
11. Approx. date of last pelvic exam: _____
12. Approx. date of last pap test: _____
13. Approx. date of last mammogram: _____
14. Are you sexually active now? ☐ Yes ☐ No
    ☐ same sex ☐ single partner ☐ opposite sex ☐ multiple partners
    Have you had more than 4 lifetime partners? ☐ Yes ☐ No
15. Birth control method _____
16. Do you have concerns about sexual orientation, sexually transmitted diseases, exposure to AIDS or other sexual concerns? ☐ Yes ☐ No
17. Do you feel safe/ comfortable in your home, with your family, and/or your partner relationship? ☐ Yes ☐ No
18. Do you have concerns you wish to discuss? ☐ Yes ☐ No

Patient Signature _____ Date _____

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