

### INITIAL WOMEN'S HEALTH ASSESSMENT

Please fill out this questionnaire as completely as possible. The information provided will become part of your medical record and is totally confidential. This information will assist us in our effort to provide quality health care.

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
(Last) (First) (Middle Initial)

DOB: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Occupation: \_\_\_\_\_

Please note the reason for your visit today \_\_\_\_\_

When was your last gyn exam? \_\_\_\_\_

#### **ALLERGIES:**

Please note any allergies or reactions to medications or other agents.  None

Medication: \_\_\_\_\_ Reaction: \_\_\_\_\_

Medication: \_\_\_\_\_ Reaction: \_\_\_\_\_

Medication: \_\_\_\_\_ Reaction: \_\_\_\_\_

#### **CURRENT PRESCRIPTION MEDICATIONS:**

Please list PRESCRIPTION medications you currently take including DOSAGE AND INSTRUCTIONS.  None

Med/Dose/Instr: \_\_\_\_\_

Med/Dose/Instr: \_\_\_\_\_

Med/Dose/Instr: \_\_\_\_\_

Med/Dose/Instr: \_\_\_\_\_

Med/Dose/Instr: \_\_\_\_\_

Please list any non-prescription medications, supplements and/or herbal remedies you take: \_\_\_\_\_

#### **GYNECOLOGIC STATUS:**

Date your last period began: \_\_\_\_\_

Was it normal?  no  yes

How often do you have periods: \_\_\_\_\_

How many days do your periods last? \_\_\_\_\_

Flow:  light  average  heavy

Do you have spotting or bleeding between periods?  no  yes

Do you have pain or cramping with your periods?  no  yes

What medications do you take for the pain or cramping? \_\_\_\_\_

Age at first period: \_\_\_\_\_

If post-menopausal, are you experiencing any vaginal bleeding?  no  yes

Have you ever been on Hormone Replacement Therapy?  no  yes

If so for how long? \_\_\_\_\_

**OBSTETRICAL HISTORY:**

Have you ever been pregnant?  no  yes If yes, how many times have you been pregnant? \_\_\_\_\_

How many children do you have? \_\_\_\_\_ **Please list all pregnancies (including miscarriages and abortions):**

Pregnancy Outcome (vaginal del, C-section, VBAC, miscarriage, ectopic, induced abortion)	Date (or Year if unsure)	How far along were you?	Problems or Complications

**MEDICAL HISTORY:**

Check if you have ever had or been diagnosed with:  None

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Absent Periods<br>(Amenorrhea)                                       | <input type="checkbox"/> Heart Murmur                          | <input type="checkbox"/> STI/Sexually Transmitted<br>Infections |
| <input type="checkbox"/> Anemia   | <input type="checkbox"/> Hepatitis/Jaundice                    | <input type="checkbox"/> Genital Herpes                         |
| <input type="checkbox"/> <input type="checkbox"/> Sickle Cell                                 | <input type="checkbox"/> HIV/AIDS                              | <input type="checkbox"/> Gonorrhea                              |
| <input type="checkbox"/> <input type="checkbox"/> Thalessemia                                 | <input type="checkbox"/> Hyperlipidemia (High<br>cholesterol)  | <input type="checkbox"/> Genital Warts                          |
| <input type="checkbox"/> Arthritis  | <input type="checkbox"/> Hypertension (High blood<br>pressure) | <input type="checkbox"/> Chlamydia                              |
| <input type="checkbox"/> Asthma   | <input type="checkbox"/> Hypertension (High blood<br>pressure) | <input type="checkbox"/> Syphilis                               |
| <input type="checkbox"/> Cancer: _____  | <input type="checkbox"/> Infertility                           | <input type="checkbox"/> Substance abuse                        |
| <input type="checkbox"/> Cerebrovascular disease<br>(Stroke/TIA)                              | <input type="checkbox"/> Inflammatory Bowel<br>Disease         | <input type="checkbox"/> Alcohol                                |
| <input type="checkbox"/> Chickenpox   | <input type="checkbox"/> Crohns                                | <input type="checkbox"/> Drugs                                  |
| <input type="checkbox"/> CAD/Heart Attack/Angina  | <input type="checkbox"/> Ulcerative Colitis                    | <input type="checkbox"/> Tuberculosis                           |
| <input type="checkbox"/> Bleeding tendency<br>(coagulation defect)                            | <input type="checkbox"/> Interstitial Cystitis                 | <input type="checkbox"/> Thromboembolic disorder                |
| <input type="checkbox"/> DES Exposure in Utero<br>(when your mother was pregnant<br>with you) | <input type="checkbox"/> Irritable Bowel                       | <input type="checkbox"/> Blood clots in legs<br>or lungs        |
| <input type="checkbox"/> Diabetes   | <input type="checkbox"/> Kidney problems/UTIs                  | <input type="checkbox"/> Uterine Anomaly                        |
| <input type="checkbox"/> <input type="checkbox"/> Only In pregnancy                           | <input type="checkbox"/> Migraine                              | <input type="checkbox"/> Abnormal uterine<br>structure          |
| <input type="checkbox"/> Painful periods<br>(Dysmenorrhea)                                    | <input type="checkbox"/> Menstrual Disorders                   | <input type="checkbox"/> Urinary Incontinence                   |
| <input type="checkbox"/> Pain with sex (dyspareunia)  | <input type="checkbox"/> Irregular or<br>infrequent periods    | <input type="checkbox"/> Vaginal dysplasia<br>(precancer)       |
| <input type="checkbox"/> Endocrine  | <input type="checkbox"/> Frequent or heavy<br>periods          | <input type="checkbox"/> Vulvar dysplasia<br>(precancer)        |
| <input type="checkbox"/> <input type="checkbox"/> Thyroid                                     | <input type="checkbox"/> Bleeding between<br>periods           | <input type="checkbox"/> Vulvodynia                             |
| <input type="checkbox"/> <input type="checkbox"/> Polycystic ovaries                          | <input type="checkbox"/> Osteoporosis                          | <input type="checkbox"/> Vulvovaginitis                         |
| <input type="checkbox"/> Endometriosis or<br>Adenomyosis                                      | <input type="checkbox"/> Ovarian Cyst                          | <input type="checkbox"/> Yeast                                  |
| <input type="checkbox"/> Fibroids, uterine  | <input type="checkbox"/> Pelvic Pain, chronic                  | <input type="checkbox"/> BV                                     |
| <input type="checkbox"/> Gastrointestinal Problem(s)  | <input type="checkbox"/> Pelvic Inflammatory<br>Disease (PID)  | <input type="checkbox"/> Other _____                            |
| <input type="checkbox"/> <input type="checkbox"/> GERD  | <input type="checkbox"/> Seizure Disorder                      | <input type="checkbox"/> Other: _____                           |

**SURGICAL HISTORY:**

List all operations (*excluding pregnancy*):  None

DATE	SURGERY

If you have you been hospitalized for anything else or had any other major injuries please note: \_\_\_\_\_

\_\_\_\_\_

**FAMILY HISTORY:** Check (✓) family members who have had any of the conditions listed below.  Adopted

Illness	Mother 1	Father 2	Sister 3	Brother 4	Mother's Mother 5	Mother's Father 6	Father's Mother 7	Father's Father 8	Other 0
Autoimmune Disease (e.g., lupus, ulcerative colitis, rheumatoid arthritis)									
CAD/Coronary Artery Disease (e.g., Heart Disease/Heart Attack)									
Cancer - Melanoma									
Cancer - Endometrial									
Cancer - Breast									
Cancer - Colon									
Cancer - Ovarian									
Diabetes									
Genetic Disorders (e.g., MD, Tay Sachs, Thalessemia, sickle cell)									
Gynecologic Problem (e.g., fibroids, infertility, early menopause, endometriosis)									
Hypertension (High Blood Pressure)									
Hyperlipidemia (High Cholesterol)									
Hypercoagulation Disorder (blood clots in legs or lungs)									
Mental Retardation									
Osteoporosis									
Stroke									
Thyroid Disease									
Other:									

**LIFESTYLE:**

Do you currently smoke cigarettes?     no, never     have exposure to second hand smoke  
 yes    Date Started: \_\_\_\_\_ Amt/PPD: \_\_\_\_\_  
 quit    Date Started: \_\_\_\_\_ Amt/PPD: \_\_\_\_\_ Date Stopped: \_\_\_\_\_

How many alcoholic drinks do you have in an average week?  none     # \_\_\_\_\_

Do you ever drink more than 3 at one sitting? \_\_\_\_\_

What recreational drugs have you used?  none  marijuana  heroin  crack  cocaine  painkillers  other \_\_\_\_\_

Have you ever used IV drugs?     no     yes

**SEXUAL HISTORY:**

Have you ever been sexually active?                     no     yes

If yes, are you currently sexually active?             no     yes

Are your partner(s)     male     female

Do you or your partner have more than one partner?                     no     yes     I don't know

Do you want to be screened for any sexually transmitted infections?     no     yes     unsure

Do you want to be screened for HIV, the virus that causes AIDS?         no     yes     unsure

Do you have any concerns about sex?  no     yes

***Birth Control***

What method of birth control, if any, are you using? \_\_\_\_\_

Are you planning a pregnancy in the next year?  no     yes

**OTHER ACTIVITIES:**

How often do you exercise?     regularly     occasionally     rarely     never

What: \_\_\_\_\_

Do you use a seatbelt?     no     yes

Do you have any concerns about weight?                     none     gain     loss

Do you take a calcium supplement?                                     no     yes

Have you been emotionally or physically abused by your partner or someone close to you?     no     yes

**IMMUNIZATIONS:**

Have you had the Tdap vaccine (combined tetanus/diphtheria/pertussis) ?     no             yes         don't know  
Have you been vaccinated against the HPV virus?                     no         yes         don't know

**REVIEW OF SYSTEMS: Check if you *currently* have *problems* with:**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> fatigue                    | <input type="checkbox"/> persistent cough           | <input type="checkbox"/> fainting/dizziness/balance |
| <input type="checkbox"/> weight loss                | <input type="checkbox"/> shortness of breath        | <input type="checkbox"/> anxiety                    |
| <input type="checkbox"/> weight gain                | <input type="checkbox"/> wheezing                   | <input type="checkbox"/> depression                 |
| <input type="checkbox"/> easy bruising              | <input type="checkbox"/> difficulty breathing       | <input type="checkbox"/> memory loss                |
| <input type="checkbox"/> enlarged glands or lumps   | <input type="checkbox"/> indigestion or nausea      | <input type="checkbox"/> trouble sleeping           |
| <input type="checkbox"/> environmental allergies    | <input type="checkbox"/> abdominal pain or bloating | <input type="checkbox"/> varicose veins             |
| <input type="checkbox"/> hot flashes                | <input type="checkbox"/> constipation               | <input type="checkbox"/> muscle or joint pain       |
| <input type="checkbox"/> heat or cold intolerance   | <input type="checkbox"/> diarrhea                   | <input type="checkbox"/> back pain                  |
| <input type="checkbox"/> excess hair growth or loss | <input type="checkbox"/> painful urination          | <input type="checkbox"/> breast pain                |
| <input type="checkbox"/> skin                       | <input type="checkbox"/> involuntary loss of urine  | <input type="checkbox"/> breast discharge           |
| <input type="checkbox"/> moles                      | <input type="checkbox"/> abnormal vaginal discharge | <input type="checkbox"/> breast lump                |
| <input type="checkbox"/> chest pain                 | <input type="checkbox"/> headaches                  | <input type="checkbox"/> Other _____                |

Primary Care Provider \_\_\_\_\_

PCP's Address \_\_\_\_\_

PCP Phone # \_\_\_\_\_

Who referred you? \_\_\_\_\_

If you would like a copy of today's visit sent to another clinician please complete below and provide your signature for authorization.

- Send to my PCP
- Send to another clinician:

\_\_\_\_\_

*Name, Title, Street Address, Town, Zip*

Signature: \_\_\_\_\_ Date: \_\_\_\_\_