Stanford HEALTH CARE

Well Woman Preventative Exam

Name: _____Age: _____ Last Menstrual Period: _____

The following questions cover important gynecologic issues for all women. We strongly encourage everyone to have a primary care physician to cover other health issues.

Please list any questions, symptoms, concerns or anything else that you would like to discuss in addition to your annual.

Health Maintenance: Please write when it was last performed.

Pap smear: _____Was it normal? Yes/No Where? _____
Have you ever had an abnormal Pap test? Yes/No
Treatment: Colposcopy/Cryotherapy/LEEP/Cone biopsy
Colonoscopy:_____Was it normal? Yes/No Where? _____
Mammogram: _____Was it normal? Yes/No Where? _____
Do you do regular breast self-examinations? Yes/No
Bone Density: _____Was it normal? Yes/No Where? _____

Vaccinations: Vaccinations can be obtained without a prescription at most pharmacies.
Influenza or flu shot: (Recommended yearly): _____
TdaP – Tetanus, Diphtheria and Pertussis or whooping cough (Recommended every 10 years) : _____
MMR: (1-2 doses if born in 1957 or later) _____
Shingles or Zoster: (Recommended after age 50) _____
Hepatitis C blood test: (Recommended once for birth between 1945-1965) _____

Occupation: _____ Marital Status: _____Partner's Name: _____
Number of pregnancies: None _____ Full term: _____ Preterm: _____ Miscarriage: _____ Termination: _____

Review of symptoms:

Circle any of the following that you are **currently experiencing** ☐**NONE**

General	Extreme Fatigue	Depression	Fever	
	Weight gain _____lbs	Weight loss _____lbs	Cold intolerance	Heat intolerance
Skin:	Rash	Change in mole		
Respiratory/Cardiac	Shortness of breath	Cough	Chest pain	Palpitations
Breast	Lump	Pain	Redness	Nipple discharge
Gastrointestinal:	Abdominal pain	Black or bloody stools	Bloating	Diarrhea
		Nausea		Change in bowel
	Constipation		Vomiting	movements
Gynecologic	Abnormal bleeding	Pain during sex	Vulvar lump	Painful cramps
	PMS Symptoms _____			
	Menopausal symptoms_____			
	Vaginal discharge _____			
Urinary	Loss of urine	Pain with Urination	Urinary frequency	Urgency
Musculoskeletal:	Muscle aches	Muscle weakness		
Neurologic:	Change in headaches	Dizziness	Numbness	

Please complete back page

Within the last year have you had any:

New medical conditions? □ None _____

Any surgery performed? □ None _____

Any new family history of:

☐Breast cancer Relationship/Age of onset _____

☐Colon cancer Relationship/Age of onset _____

☐Ovarian cancer Relationship/Age of onset _____

☐Other Relationship/Age of onset _____

Drug Allergies: ☐ None ☐ Yes, List with reaction: _____

Latex allergy: ☐ YES ☐NO

Current Medications (if refill desired, check box)

Refill	Name and Dose	How are you taking it?
□		
□		
□		
□		

Preferred Pharmacy ☐Mail Order Name: _____ City: _____

Gynecologic History:

Age Periods Began: _____ Length of Period (days): _____ Number of days between periods: _____

Date of last menstrual period: _____ □ None due to □ Hysterectomy □ Menopause

Do you have menstrual cramps? Yes/No

Sexually Active: □Yes □No □Never

Partner: □Male □Female □Both

How many sexual partners have you had within the last year? _____

Any problems with intercourse? _____

Contraception or Birth Control:

Abstinence Withdrawal Condom Diaphragm Foam Spermicide Sponge

Pill Ring Depo-Provera Patch

Nexplanon (inserted _____) IUD Type: _____ Inserted: (_____) Tubal Ligation

Vasectomy

Do you want to change your current method? □No □Yes

Are you thinking of conceiving in the next year? □ No □ Yes

Social History:

Tobacco Use: Never smoked Current Smoker Former SmokerReady to quit? □ Yes □ No

Packs of cigarettes each day: _____ Number of years smoked? _____

Smokeless Tobacco Never smoked Current Smoker Former SmokerReady to quit? □ Yes □ No

E-cigarettes: Never smoked Current Smoker Former SmokerReady to quit? □ Yes □ No

Alcohol use: Do you drink alcohol? □ Yes □ No If yes, Drinks each week: _____

Recreational drug use: □ Yes □ No

Type: Marijuana Methamphetamine Ecstasy Cocaine Heroin Prescription Drug

Have you been a victim of abuse or domestic abuse? □ Yes □ No

----------For Clinic Use Below----------

Height _____

Weight _____

Blood Pressure _____/_____

Orders: □ Pap Smear □ Mammogram □ Labs □ DXA □ STI □ GC/Chlamydia

Please register for chart access at https://myhealth.stanfordhealthcare.org