PATIENT INFORMATION

Coury Family Medicine

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WELL WOMAN EXAM Date: _____

Patient Name: (Last)_____ (First)_____ (MI)___ **Date of Birth**:_____

Gynecologic History
First day of last menstrual period:_____
How many days in between your cycles?_____
How long does your period last?_____
Do you have:
Pelvic Pain? *YES NO*
Any vaginal discharge or sores? *YES NO*
Pain with intercourse? *YES NO*
Bleeding after intercourse? *YES NO*
Have you ever taken any hormone replacement therapy? *YES NO* If yes, when? _____
If post-menopausal, have you had any bleeding since you went through menopause? *YES NO*

Pregnancy History
Number of times you have been pregnant?____
Number of completed pregnancies?_____
Could you currently be pregnant?_____

Family Planning
Are you sexually active? *YES NO*
What do you use for birth control?_____
How many partners have you had?_____
Have you ever had an STD? *YES NO*
If yes, what kind?_____
Would you like STD screening? *YES NO*

Pap History
Have you ever had an abnormal pap? *YES NO*
If yes, when?:_____
What kind of abnormality? _____
Was a colposcopy performed? *YES NO*

Pelvic/Abdominal Surgeries
Have you ever had pelvic surgeries? *YES NO*
If yes, what for?_____
Have you ever had a colonoscopy? *YES NO*
If yes, when?_____
Any abnormal findings? *YES NO*

Osteoporosis History
Prior screenings for Osteoporosis? *YES NO*
If yes, when and results?_____
Taking calcium and vitamin D? *YES NO*
Any history of fractures as an adult? *YES NO*

Mammogram History
Have you ever had a mammogram? *YES NO*
If yes, when:_____
Any abnormal mammograms? *YES NO*
If yes, when? _____
Did you have? *Biopsy Cyst drained? Surgery?* _____:
Do you perform self-breast exams? *YES NO*
Any breast lumps, nipple discharge or other concerns? *YES NO* _____

Past Medical History
Please circle if you have had now or any of the following medical conditions:
*Allergies, Anemia, Anxiety, Depression, Arthritis, Blood Clots: where?*_____
*Cancer: where?*_____*Diabetes, Heart Disease, High Blood Pressure, High Cholesterol, Lung Disease: Asthma COPD Emphysema, Migraine*
*Skin Disorder: what kind*_____
Other?_____

Family History
Do you have a parent or sibling with a history of colon, breast, uterine, prostate or ovarian cancer or osteoporosis, depression, or heart disease? *YES NO*
If yes, what family member, and what disease?
_____
_____
_____

Prevention History
Do you eat a well-balanced diet that is low in sugar and fats? *YES NO*
Do you exercise regularly? *YES NO*
Days per week:_____Length:_____
Type of exercise:_____
Last Tetanus shot:_____ Flu shot:_____
Last EKG:_____
Tobacco use? *YES NO* How long? _____
Gardasil (HPV) vaccine? *YES NO*