Established Well Women Questionnaire

Name: _____ Today's date: _____

Reason for Today's visit: _____ Date of birth: _____

Do you use your "My Mercy" account: No____ Yes____.

Gynecologic History:

Date of first day of your last period: _____. Any problems with your period: _____

How often are your periods: _____. How long do they last: _____

Are you currently sexually active: No ___Yes ___ if yes, what form of contraceptive are you or your partner using (including tubal sterilization or vasectomy):_____

Are your partners: Men____ Women _____Both_____.

Do you have any questions regarding sexual relations: Yes_____ No_____.

Have you ever had a sexually transmitted disease: No_____ Yes _____.Herpes ____, Gonorrhea ____, Chlamydia ____, HIV____, Genital Warts____, Syphilis____, Pelvic Inflammatory Disease (PID) _____ Other_____.

Date of last Pap smear: _____Normal _____or Abnormal_____. If Abnormal what was the date: _____.

Date of last mammogram: _____, Normal_____, Abnormal_____.

Date of last Bone density: _____. Date of last Colonoscopy: _____.

Have you had a Hysterectomy: No____ Yes_____. If yes, were your ovaries removed: No____ Yes_____.

Any changes to family history since your last visit: _____.

SURGERY, HOSPITALIZATIONS OR INJURIES: (since last visit)

Date: Procedure/Reason Hospital Complications_____

_____

_____

SOCIAL HISTORY:

Do you smoke: No____ Yes____ Packs per day_____ How long:_____

Do you drink alcohol: No_____ Rarely_____ Occasionally_____ Often_____ Daily _____

Do you use drugs socially: No_____ Rarely_____ Occasionally_____ Often_____ Daily_____: Marijuana_____

Cocaine_____ Crack_____ Heroin_____ Methamphetamine _____Other_____ Last used_____

Do you exercise regularly: No_____ Yes_____. Do you do self-breast exam: No_____ Yes_____.

Are you: Single_____ Married_____ Partnered_____ Divorced_____ Separated_____ Widowed_____

Have you been physically or mentally abused by your spouse or partner: No_____ Yes_____

Have you ever been sexually abused, raped or date raped: No _____, Yes_____. If yes, do you wish to discuss this: _____

Do you wear your seat belt: No_____ Yes_____.

Current or most recent occupation:

_____

Any changes to your Medications since your last visit: _____

REVIEW OF SYSTEMS:

Please "circle" any of the following that you are experiencing:

Abnormal Thirst	Anxiety	Bleeding problems	Breast masses	Blood in urine	Bloody stools
Chest pain	Constipation	Cough	Coughing up blood	Crying spells	Dental problems
Depression	Dry skin	Fatigue	Fever	Frequent diarrhea	Hair loss/growth
Headaches	Hot flashes	Leaking stools	Leaking urine	Loss of vision	Nausea/vomiting
Painful intercourse	Pain in breast	Pain with urination	Seizures	Shortness of breath	Sinus problems
Sleep problems	Sore throat	Swelling of legs	Urinary urgency	Vision changes	Wheezing

Patient Signature_____