

Well Woman Questionnaire

Name: _____

1. Do you have any lumps in your breasts? Yes No Details _____
2. Are you experiencing any significant breast tenderness at times other than just before your menses? Yes No Details _____
3. Are you having any nipple discharge? Yes No Details _____
4. Are you having any urinary difficulty? Yes No Details _____
5. Do you have any sexual problems? Yes No Details _____
6. Do you have any vaginal discharge/sores? Yes No Details _____
7. Is there a family history of ovarian cancer? Yes No Details _____
8. Is there a family history of prostate cancer? Yes No Details _____
9. Do you have any HIV risk factors? Yes No Details _____
10. Would you like to be tested for HIV and/or other STD's? Yes No
11. Have you ever had a DVT (a large blood clot or blood clotting problems)? Yes No Details _____

12. How old were you when you started your menstrual cycle? _____
13. Are you having menstrual cycles? Yes No
 If "No", Year of last menstrual period: _____ If "Yes", Last menstrual period _____
 Reason: Uncertain Are your periods regular? Yes No
 Pregnant Details _____
 Hysterectomy w/out ovaries Method of Birth Control:
 Postmenopausal Abstinence
 Hysterectomy with ovaries removed Birth Control Pills
 Continuous hormone therapy Condoms
 Patch Hysterectomy
Hormone Replacement Therapy (HRT)? Nuva-Ring
 Currently Rhythm
 Previously Bilateral tubal ligation (tubes tied)
 Never Vasectomy
Any problems with HRT? Yes No
 Details _____
14. Have you ever been pregnant? Yes No
 how old were you when pregnant with first child? _____
 how many pregnancies have you had? _____
 did you breast feed any of your children? Yes No
 have you ever had a miscarriage? Yes No
 if so, how many? _____

Please continue on next page

15. When was your last Pap smear? _____
16. Have you ever had a Pap smear that was not normal? _____ Yes _____ No Details _____
17. Do you perform monthly breast examinations? _____ Yes _____ No Details _____
18. When was your last mammogram? _____
19. Have you ever had a mammogram that was not normal? _____ Yes _____ No Details _____
20. Is there a family history of breast cancer or ovarian cancer? _____ Yes _____ No Details _____
21. When was your last bone density scan? _____
22. Is there a family history of osteoporosis _____ Yes _____ No Details _____
23. Have you fractured/broken any bones? _____ Yes _____ No Details _____
24. Are you taking at least 1000 mg calcium supplement daily? _____ Yes _____ No _____ Occasionally
- a. Are you taking Vitamin D? _____ Yes _____ No If "Yes" what dose: _____
25. Do you have any other female problems? _____ Yes _____ No Details _____