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: _____

Reason:

_____ Uncertain
_____ Pregnant
_____ Hysterectomy w/out ovaries
_____ Postmenopausal
_____ Hysterectomy with ovaries removed
_____ Continuous hormone therapy

Hormone Replacement Therapy (HRT)?

_____ Currently
_____ Previously
_____ Never

Any problems with HRT? _____ Yes _____ No
Details _____

If "Yes", Last menstrual period _____

Are your periods regular? _____ Yes _____No
Details _____

Method of Birth Control:

_____ Abstinence
_____ Birth Control Pills
_____ Condoms
_____ Hysterectomy
_____ Patch
_____ Nuva-Ring
_____ Rhythm
_____ Bilateral tubal ligation (tubes tied)
_____ Vasectomy

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 _____