Avenues For Health

Annual Well Woman Patient Questionnaire

Name_____ Age_____ Date_____

Any changes in your health since your last visit? __Yes __ No If yes, explain

_____

_____

Medications (*this includes birth control pills, hormones and all prescription meds)*

Name of Medicine Dosage (mg) Dose schedule

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Vitamins & Supplements *(bring vitamins & supplements in with you if possible)*

1, _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

Health Habits

Exercise: __Yes __No __Rarely

Aerobic: Type(s)_____ #Days per wk ____ # Minutes _____

Strength Training: Type(s)_____ #Days per wk ____ # Minutes _____

Do you practice Meditation, Yoga or Tai Chi? __ Yes __ No __Other_____

Is your diet? __Very healthy __Healthy __Variable __Poor

Do you have any special dietary restrictions? __Vegetarian __Other _____

Do you have any dietary goals? _____

Smoke: __Never __Quit/When_____ __Yes How many per day?_____

Alcohol: __Daily __More than 4 drinks per wk __Less than 4 drinks per wk

Do you have any health concerns about the amount you drink? __Yes __No

Do you have any concerns about your use of prescription or recreational drugs?

__Yes __ No _____

Do you use medical Marijuana? __Yes __ No

Any Changes in Social History?

__Single __Married __Divorced __Partnered __Dating __Widow __Poly

Current job/occupation _____

Stress level: __Extremely High __ High __Moderate __Low
Stress Management: __Very Good __Good __Fair __ Moderate __Poor

Gynecologic History
Last menstrual period _____, Periods come every___ days, Periods last ___days
Have you stopped having periods? __Yes __No __Changing
Any problems with periods? __Yes __No Explain_____
Do you have PMS that significantly bothers you? __Yes __No
Do you have a need for birth control? __ Yes __ No
Birth Control Method: __Pill __Patch __Ring __ Depo __IUD __Diaphragm
__Condom __Vasectomy __ Tubal Other_____ __None
Are you happy with your current birth control method? __Yes __No

Sexual health
Do you have any sexual concerns? __Yes __No Explain_____
Is/are your sexual partner(s) *circle all that apply* __ Male __ Female __ None
__ Trans__ other
Are you satisfied with your intimate relationship(s)? __ Yes __ No
Pain with intercourse? __Yes __ No Decreased Libido? __Yes __No
New sexual partner? __Yes __No Unprotected sex? __Yes __No
Do you want an STI screen? __Yes __No HIV test? __Yes __No
Do you have; __Vaginal Discharge __Vaginal Itching __Vulvar Lesions
__Pelvic Pain __History of Genital Herpes __History of Genital Wart

Do you have menopausal symptoms that significantly bother you? __Yes __No
Are you on hormone therapy? __Yes __No Any concerns? __Yes __No
If yes, when did you first start HT? _____

Family Medical History *(circle any new condition)*
__Breast Cancer __Colon Cancer __Osteoporosis __Melanoma
__Heart Attacks __Stroke __High Blood Pressure __Diabetes
__Dementia /Alzheimer's __Depression __Bipolar Disorder
__Uterine Cancer __ Pancreatic Cancer __ Kidney/Bladder cancer
__Other _____

Hospitalizations and/or Operations since last annual
_____
_____

Do you currently have?
__Weight Change: __Up __Down __Appetite Change: __Increase __Decrease
__ Bloating __Change in Bowel Habits __Blood in Stool __Breast Lump

__Depression __ Anxiety __Chest Pain __Breathing Problem __Urine Leakage
__Bladder Problem __Pain __Headaches __Fatigue __Insomnia

Are you experiencing any verbal, emotional or physical abuse? __Yes __No
Do you feel safe at home? __ Yes __No
Are there guns in your home? __Yes __No If yes are they locked up? _____

Do you have any additional questions or health concerns? *These may have to be addressed at a separate appointment*

_____
_____
_____