# Well Woman Visit Health History

**Name:**_____

**Date:**_____ **Age:** _____

**REVIEW OF SYSTEMS**: please check if you are experiencing any of the following:

| | | | |
|---|---|---|---|
| Fatigue | Hoarseness | Bowel Changes | Weak Muscles |
| Hot Flashes | Chronic cough | Constipation | Fainting |
| Night Sweats | Wheezing | Black, tarry stool | Dizziness |
| Weight gain/loss | Breast Mass | Rectal Bleeding | Anxiety |
| Changing moles | Breast Pain | Urinary Burning | Sleep Changes |
| New Skin Lesions | Nipple Discharge | Frequent urination | Depression |
| Rash | Chest Pain | Incontinence | Sleep problems |
| Sinusitis (recurs?) | Leg Swelling | Irregular Periods | Depression |
| Visual Changes | Palpitations | Vaginal Discharge | Sexual dysfunction |
| Headache | Short of Breath | Joint Pain | Easy Bruising |
| Hearing Decrease | Abdominal Pain | Joint Swelling | Enlarged Glands |

**ALLERGIES**: (please include type of reaction e.g. hives, rash etc.)

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**MEDICATIONS**: (please list all current medications, including birth control pills, vitamins, supplements)

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**ROUTINE HEALTH MAINTENANCE**: (please list date and results of last exam)

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|---|
| Cholesterol Test: |
| Colon Cancer Screening: |
| Eye Exam: |
| Do you wear corrective lenses?: |
| Mammogram: |
| Self Breast Exam: |
| Pap Smear: |
| Bone Density test: |

**SOCIAL HISTORY**

Alcohol use: ____none ____1-2 drinks/week ___3-5 drinks/week ___>6 drinks/week

Drug use:_____

Exercise: ___none ___1-2 times/week ___3-5 times/week ___>6 times/week

what type of exercise?_____

**Safety**: Are there guns in your home? _____Are they locked? _____

Do you wear seatbelt in the car?_____

Do you have smoke detectors in your home? _____

Do you wear a helmet when riding bicycle or motorcycle? ____

**Sexual Activity**: Currently active? _____ new partner ___yes ___no Using condoms:?___yes ___no

Birth control type?_____

**Tobacco use**: currently smoking? ___yes ___no. Number of packs per day: _____

Years of smoking: _____ Interest in quitting? ____yes ____no

Pregnancy history: # of pregnancies: _____ # of deliveries: _____ # of miscarriages/abortions: _____

Last menstrual Period: (first day)____/____/_____

**FAMILY HISTORY** (note whether on the father's side or mother's side of family)

| | |
|---|---|
| Alcohol Abuse | Osteoporosis |
| Brain Cancer | Ovarian Cancer |
| Breast Cancer | Rheumatoid Arthritis or Lupus |
| Cervical or Uterine Cancer | Stomach Cancer |
| Colon Cancer | Stroke |
| Depression | Thyroid Cancer |
| Diabetes | Thyroid Disease |
| Heart Disease/Attack | Tuberculosis |
| High Cholesterol | Other: |
| High Blood Pressure | |
| Melanoma | |

Anything new this year that you would like us to know about?