Stanford HEALTH CARE

Well Woman Annual Preventative Care

Preferred Name:_____ **Age:**_____ **Last period:**_____

Period: Regular Irregular Menopause Hysterectomy Ablation IUD Type:_____ Birth Control pills

Please list any questions, symptoms, concerns or anything else that you would like to discuss in addition to your annual.

Please answer the following questions to the best of your ability.

New medical conditions or surgeries since your last visit: ☐ None_____

Over the past 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several Days	More than ½ the Days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3

3. Are you currently in a relationship where your partner makes you feel unsafe? ☐ Yes ☐ No

4. In the past, have you experienced physical or emotional abuse? ☐ Yes ☐ No

Drug Allergies ☐ None ☐ Yes, List with reaction:_____

Latex Allergy ☐ Yes ☐ No

Current Medications: (circle if refill needed) _____

Sexually Active: ☐ Yes ☐ No ☐ Not currently Partner: ☐ Male ☐ Female ☐ Both

Current Contraception:_____ Do you want to change your current method? ☐ Yes ☐ No

History of STD's? ☐ Yes ☐ No Type?_____

Occupation:_____ Relationship Status:_____ Partner's Name:_____

Number of pregnancies: None_____ Full term_____ Preterm:_____ Miscarriage:_____ Termination:_____

Review of symptoms: Check any of the following that you are **currently experiencing** ☐ **NONE**

General:	☐ Extreme Fatigue	☐ Depression	☐ Fever	
	☐ Weight gain_____lbs	☐ Weight loss_____lbs	☐ Cold intolerance	☐ Heat intolerance
Skin:	☐ Rash	☐ Change in mole		
Respiratory/ Cardiac:	☐ Shortness of breath	☐ Cough	☐ Chest pain	☐ Palpitations
Breast:	☐ Lump	☐ Pain	☐ Redness	☐ Nipple discharge
Gastrointestinal:	☐ Abdominal pain	☐ Black or bloody stools	☐ Bloating	☐ Diarrhea
	☐ Constipation	☐ Nausea	☐ Vomiting	☐ Change in bowel movements
Gynecologic:	☐ Abnormal bleeding	☐ Pain during sex	☐ Vulvar lump	☐ Painful cramps
	☐ PMS Symptoms_____			☐ Genital herpes
	☐ Menopausal symptoms_____			☐ Genital warts / HPV
	☐ Vaginal discharge			
Urinary:	☐ Loss of urine	☐ Pain with urination	☐ Urinary frequency	☐ Urgency
Musculoskeletal:	☐ Muscle aches	☐ Muscle weakness		
Neurologic:	☐ Change in headaches	☐ Numbness	☐ Dizziness	

For Nursing and Doctors: Height_____ Weight_____ BP_____

Orders: ☐ Pap smear ☐ Mammogram ☐ Labs ☐ DXA ☐ STI ☐ GC/CT ☐ Immunizations _____

Any new family history of:

☐ **Breast cancer** **Relationship / Age of onset** _____

☐ **Colon cancer** **Relationship / Age of onset** _____

☐ **Ovarian cancer** **Relationship / Age of onset** _____

☐ **Other** **Relationship / Age of onset** _____

Social History:

Tobacco Use: ☐ Never smoked ☐ Current Smoker ☐ Smokeless Tobacco ☐ Former Smoker

Ready to quit? ☐ Yes ☐ No

Packs of cigarettes each day: _____ Number of years smoked? _____

E-cigarettes: ☐ Never smoked ☐ Current Smoker ☐ Former Smoker Ready to quit? ☐ Yes ☐ No

Alcohol use: Do you drink alcohol? ☐ Yes ☐ No If yes, Drinks each week: _____

Recreational drug use: ☐ Yes ☐ No

Type: ☐ Marijuana ☐ Methamphetamine ☐ Ecstasy ☐ Cocaine ☐ Heroin ☐ Prescription Drug

Vaccinations: Please document dates given, if requesting Vaccinations today please circle

Flu shot: (recommended yearly) _____

TdaP - Tetanus, Diphtheria, and Pertussis or whooping cough (recommended every 10 yrs) _____

Shingles or Shingrix: (recommended after age 50) _____

Pneumococcal: (recommended after age 60 OR younger with risk factors) _____

Gardasil: (HPV Immunization - 3 dose series) _____

Health Screening:

Hepatitis C blood test (one time testing for those born 1945-1965) _____

Have you had recent blood work? Who has the results? _____

What other doctors do you have: _____

_____

These questions cover important gynecological issues for all women. We strongly encourage everyone to have a Primary Care Physician to cover other health issues.

Please register for chart access at https://myhealth.stanfordhealthcare.org