Stanford HEALTH CARE

Label

Well-Woman Preventative Exam

Preferred Name: _____ Age: _____ LMP:_____

Do you have other concerns you would like to address at this visit?

_____

The following questions will help your provider determine the recommended services offered to you at your visit.

Over the past 2 weeks, how often have you been bothered by any of the following: *(Please x response)*

1. little interest or pleasure in doing things
2. feeling down, depressed or hopeless

Have you been pregnant or delivered a child since your last visit with us?

Within the last year, have you had new diagnosed medical conditions?

_____

Within the last year, have you had surgery performed?

_____

Please list any new allergies to medications/drugs or food since your last visit with us: _____

FAMILY HISTORY Within the last year, any immediate family been diagnosed with? *please list below* ☐ None

Breast Cancer _____ Colon Cancer _____

Ovarian Cancer _____ Other Cancer_____

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
	☐ PMS symptoms_____			
	☐ Menopausal symptoms_____			
	☐ Vaginal discharge_____			
Urinary:	☐ Loss of urine	☐ Pain with urination	☐ Urinary frequency	☐ Urgency
Musculoskeletal:	☐ Muscle aches	☐ Muscle weakness		
Neurologic:	☐ Change in headaches	☐ Dizziness	☐ Numbness	

Clinic Use Only: Height _____ Weight _____ BP _____

Orders: ❑ Pap smear ❑ Mammogram ❑ DXA ❑ STI ❑ CT/GC ❑ Labs ❑ Immunization_____ ❑ Referral

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CONTRACEPTION (***Skip section if no longer having periods)***

What is your current method of birth control? _____

Are you satisfied with your current method? Do you want to change?

you thinking of conceiving in the next year?

SEXUAL HEALTH

Are you sexually active? Partners:

Have you had more than one partner this year?

Any problems with intercourse?

Have you been hit, kicked, punched, or otherwise hurt by someone in the past year?

Do you feel safe in your current relationship?

Is there a partner from a previous relationship who is making you feel unsafe now?

MENSTRUAL HISTORY

Still having periods, please answer the following:

Are you experiencing a period problem you would like to discuss?

No longer having periods, please answer the following:

Are you taking or have taken hormone therapy?

SOCIAL HISTORY

Do you currently use tobacco products?

How often do you use:

Tobacco?	☐ Type:	☐ year quit: _____
E-Cigarette?		☐ year quit: _____
Smokeless Tobacco?		☐ year quit: _____
Alcohol?		☐ year quit: _____
Marijuana?		☐ year quit: _____
Recreational Drugs?	☐ Type:	☐ year quit: _____

PREVENTATIVE HEALTH HISTORY

Do you perform regular breast self-examinations?

Have you had a blood test for Hepatitis C?

Immunizations	*Please write dates last received*	
	Influenza (flu): _____	*Recommended yearly*
	Tdap:_____	*Recommended every 10 years*
	Pneumococcal:_____	*Recommended after age 60 or younger with risk factors*
	Shingles or Zoster: _____	*Recommended after age 50*
	HPV (Gardasil):_____	☐ Series completed (2 or 3 dose)
	Covid 19:_____	Brand: ☐ Pfizer ☐ Moderna ☐ J&J ☐ Other