WOMEN'S HEALTH QUESTIONNAIRE UPDATE

Since your last visit to our office, your life may have changed and this may affect your health. Please help us to provide the best health care for you by completing this short questionnaire.

NAME ______________________ DATE ______________________

What brings you to our office today? ______________________

Section A:	*Circle One*		***If yes, please specify…***
Have you changed your occupation?	Yes	No	______________
Do you have any problems at home that you notice affect your health or stress level?	Yes	No	______________
Has there been any significant change in your relationship with your husband, partner, or boyfriend?	Yes	No	______________
Do you have periods? If Not skip to Section B			
Has there been a change in your menstrual period?	Yes	No	______________
Do you have any problems with your period?	Yes	No	______________
Date of your last period ______________			
Do you use a method of contraception? If yes, what type? Pills, NuvaRing, IUD, Diaphragm, Condoms, Natural/Rhythm, Spermicide,Other: ______________	Yes	No	Do you use it regularly? Are you/your partner satisfied with this method? ______________
Do you want any information about birth control?	Yes	No	______________

Section B:	*Circle One*		***If yes, please specify…***
Date (Year) of your last Pap test ______________			
Do you have any questions about safer sex?	Yes	No	______________
Do you smoke cigarettes?	Yes	No	How many per day? ______________
Do you use street drugs?	Yes	No	
Do you drink alcohol?	Yes	No	How often? How much? ______________
Have you ever felt the need to cut down your drinking?	Yes	No	______________
Are you exercising?	Yes	No	How often? What type? ______________
Have you had any illnesses?	Yes	No	______________
Have you seen any of your other doctors recently?	Yes	No	Please list: ______________
Are you taking any medicines now?	Yes	No	Please list: ______________
Do you have allergies to any medications?	Yes	No	Please list: ______________
Do you have uncontrolled urine loss?	Yes	No	______________

Approximate date of last Flu Vaccination ______________

Approximate date of last Pneumonia Vaccination ______________

Please answer if you are over 39:

Approximate date of your last mammogram ______________

Approximate date of your last colonoscopy ______________

Approximate date of last bone density exam (heel or spine/hip) ______________

Approximate date of your last cholesterol test ______________

Would you like more information on new testing available for early cancer detection and/or osteoporosis? Yes No

Do you have any other questions, problems or concerns that you would like to discuss with us today?

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The Patient Health Questionnaire (PHQ-9)

Patient Name ______________________ Date of Visit __________

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not At all	Several Days	More Than Half 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. Trouble falling asleep, staying asleep, or sleeping too much	0 ☐	1 ☐	2 ☐	3 ☐
4. Feeling tired or having little energy	0 ☐	1 ☐	2 ☐	3 ☐
5. Poor appetite or overeating	0 ☐	1 ☐	2 ☐	3 ☐
6. Feeling bad about yourself - or that you're a failure or have let yourself or your family down	0 ☐	1 ☐	2 ☐	3 ☐
7. Trouble concentrating on things, such as reading the newspaper or watching television	0 ☐	1 ☐	2 ☐	3 ☐
8. Moving or speaking so slowly that other people could have noticed. Or, the opposite - being so fidgety or restless that you have been moving around a lot more than usual	0 ☐	1 ☐	2 ☐	3 ☐
9. Thoughts that you would be better off dead or of hurting yourself in some way	0 ☐	1 ☐	2 ☐	3 ☐

Column Totals ______ + ______ + ______

Add Totals Together ______________

10. If you checked off any problems, how difficult have those problems made it for you to Do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult