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?

_____