Jacksonville Children's and Multispecialty Clinics
Well Woman History Form

Pregnancy History

Have you ever been pregnant? ____ Yes ____ No
If yes, list outcomes of pregnancies below:
Full-term (38 weeks+) ____ Premature ____ Abortions ____ Miscarriages ____ Living Children ____
Are you currently pregnant? Yes ____ No ____ Possible ____ Not possible ____
Are you thinking about becoming pregnant? Yes ____ No ____
What type of birth control do you currently use?_____

Menstrual History

Date of last menstrual period ____/____/_____
Are your periods (please circle one) regular irregular?
How often do your periods occur? _____
Do you have pain or cramps with your period? No ____ Yes ____
Do you have heavy bleeding or pass large clots with your period? No ____ Yes ____

Menopausal Symptoms (complete only if applicable)

How old were you at the time of your last period? ____
Select Postmenopausal type:
____ Hysterectomy with ovaries remaining (___ left ____ right ____ unsure)
____ Hysterectomy without ovaries remaining
____ Natural
Have you taken hormone replacement therapy? No ____ Yes ____ Number of years ____
If yes, what type did you take (check all that apply)?
____ estrogen
____ estrogen/progesterone
____ progesterone
____ reloxifen
Do you currently have any menopausal symptoms?
Hot flashes No ____ Yes ____
Insomnia No ____ Yes ____
Night sweats No ____ Yes ____
Vaginal dryness No ____ Yes ____

Breast Health

Do you have any nipple discharge? No ____ Yes ____
Do you have any lumps in your breasts? No ____ Yes ____
Do you have any breast pain? No ____ Yes ____
For women ages 30 and above, do you perform breast self-exams? No ____ Yes ____

Additional Symptoms

Do you have any of the following?

Abnormal bleeding	No ____ Yes ____	Night-time urination	No ____ Yes ____
Anxiety	No ____ Yes ____	Sexual dysfunction	No ____ Yes ____
Decreased sex drive	No ____ Yes ____	Urinary leakage	No ____ Yes ____
Depression	No ____ Yes ____	Urinary urgency	No ____ Yes ____
Difficulty falling asleep	No ____ Yes ____	Vaginal discharge	No ____ Yes ____
Painful intercourse	No ____ Yes ____	Vaginal itching	No ____ Yes ____
History of infertility	No ____ Yes ____		

Nutrition (please check)

Calcium supplement No ____ Yes ____
Vitamin D supplement No ____ Yes ____
Multivitamin No ____ Yes ____
Folic acid No ____ Yes ____

Exercise (please check)

Activity level: ____ moderate ____ sedentary ____ vigorous
Exercise frequency: ____ 2-3 times/week ____ 3-4 times/week ____ daily ____ never ____ occasionally

Tobacco Use

Do you or have you ever used any tobacco products? No ____ Yes ____
If yes, what type(s) (check all that apply):

Type	***Amount***	***Number of Years***	***Current Use***	***Ever tried to quit***
____ chewing	oz./day _____	_____	No ____ Yes ____	No ____ Yes ____
____ cigar	cigars/day _____	_____	No ____ Yes ____	No ____ Yes ____
____ cigarettes	packs/day _____	_____	No ____ Yes ____	No ____ Yes ____
____ pipe	pipes/day _____	_____	No ____ Yes ____	No ____ Yes ____
____ smokeless	oz./day _____	_____	No ____ Yes ____	No ____ Yes ____
____ snuff	oz./day _____	_____	No ____ Yes ____	No ____ Yes ____

Are you exposed to passive smoke? No ____ Yes ____

Alcohol Use

Do you drink alcohol? No ____ Yes ____
If yes, what type(s) (check all that apply):

Type	***Amount***	***Number of Years***	***Current Use***	***Ever tried to quit***
____ beer	_____	_____	No ____ Yes ____	No ____ Yes ____
____ wine	_____	_____	No ____ Yes ____	No ____ Yes ____
____ liquor	_____	_____	No ____ Yes ____	No ____ Yes ____