SUSQUEHANNA OB/GYN
NURSE MIDWIFERY

WELL WOMAN VISIT QUESTIONNAIRE

At Susquehanna OB/GYN, our efforts to bring you the highest quality health care have led us to define what exactly is covered in your routine gynecologic visit with us. Terms such as "yearly exam" and "annual Pap" are often used, but in fact, your routine gynecologic care may not require a Pap smear or even need to be yearly!

What follows below are questions that we think cover important gynecologic issues for all women. We call this the routine Well Woman Exam. Although for many women their main health care concerns are about their reproductive well-being, we strongly encourage everyone to have a family doctor or internist to cover other health issues.

We also recognize that often it is a specific problem that brings you to our office. Sometimes we are able to combine routine care with a "problem visit", but time constraints frequently require that we ask you to come back for another visit to address all your concerns appropriately.

Please answer the questions below to aid us in your Well Woman Visit. If you are uncertain how to answer, please ask our staff or your provider.

Your Name: _____ ***Date:*** _____

Age: _____ | Last visit with us: ☐ New patient ☐ Approximately 1 year ago ☐ Other:

Menstrual Concerns: Please check all that apply.

☐ Menopause, no periods for more than one year. Last period: _____

- Any menopausal symptoms? ☐ Yes ☐ No
- Any bleeding/spotting recently? ☐ Yes ☐ No
- Any hot flashes or night sweats? ☐ Yes ☐ No

☐ Still having periods. Last period: _____

- Are cycles regular? ☐ Yes ☐ No
- What is cycle length? ☐ Every _____ days/weeks ☐ Irregular
- How long does period last? ☐ Days: _____
- Is period heavy? ☐ Yes ☐ No
- Is period painful? ☐ Yes ☐ No *Does pain interfere with normal activities?* ☐ Yes ☐ No

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Vaginal or Vulvar Symptoms: Please check all that apply.

☐ None ☐ Discharge ☐ Ulcers ☐ Rash ☐ Pain or irritation

☐ Odor ☐ Growths/bumps ☐ Dryness ☐ Protrusions

Contraception/Pregnancy Planning: Please check all that apply.

☐ Menopause ☐ Not having intercourse ☐ None, pregnancy would be okay ☐ Withdrawal

☐ IUD ☐ Vaginal ring ☐ Partner has a vasectomy ☐ Natural family planning

☐ Implanon ☐ Depo-Provera shot ☐ Tubaligation/hysterectomy ☐ Condoms or diaphragm

☐ Patch ☐ Birth control pills *(Please specify: _____)* ☐ Actively attempting pregnancy

☐ Considering pregnancy *(Time frame? _____)* ☐ None, I need more information

Sexually Transmitted Infections (Venereal Diseases)

Are you concerned about your exposure to sexually transmitted infections?	☐ Yes	☐ No
Do you or your partner have other sexual partners currently?	☐ Yes	☐ No
Do you want testing for sexually transmitted diseases today?	☐ Yes	☐ No

Cervical Cancer Screening (Pap Smears)

Have you had any abnormal Pap smears requiring biopsy or colposcopy?	☐ Yes	☐ No
Have you had any "pre-cancers" of the cervix that have required treatment?	☐ Yes	☐ No
Have all of your Pap smears and cervical treatments been through our offices?	☐ Yes	☐ No
Have you or your children had the HPV vaccine?	☐ Yes	☐ No

Breast Cancer Screening (Mammograms)

Have you had breast cancer?	☐ Yes	☐ No
Have you ever had a breast biopsy?	☐ Yes	☐ No
When was your last mammogram?	☐ Never	☐ *Please specify: _____*
Do you have any breast symptoms or concerns today?	☐ No	☐ Yes *(Please specify: _____)*

Urinary Symptoms: Please check all that apply.

☐ None ☐ Burning with urination ☐ Blood in your urine

☐ Incontinence (unwanted loss of urine) ☐ Frequent urination

☐ Inability to get to the bathroom in time (urgency) ☐ Getting up more than twice at night to urinate

Are any of these symptoms bad enough to treat? ☐ Yes ☐ No

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Sexual Concerns

Are you sexually active? ☐ Yes ☐ No

Do you have any sexual concerns or questions? ☐ Yes ☐ No

Do you have sex: ☐ Only with men ☐ Only with women ☐ Both

Sexual problems: ☐ Pain with sex ☐ Decreased interest ☐ Partner has decreased interest

Other concerns: _____

Are these problems causing marital distress? ☐ Yes ☐ No

Domestic Violence

Have you ever been in a physically, sexually or emotionally abusive relationship? ☐ Yes ☐ No

Have you ever received counseling for this? ☐ Yes ☐ No

Are you now in a physically, sexually or emotionally abusive relationship? ☐ Yes ☐ No

Do you have fears for your personal safety? ☐ Yes ☐ No

Are there issues you would like to talk about today? ☐ Yes ☐ No

Osteoporosis Screening

Have you ever been tested for osteoporosis? ☐ Yes ☐ No ☐ *Date/results:* _____

Do you take vitamin D or calcium supplements? ☐ Yes ☐ No

Please check all that apply to you:

☐ Smoking ☐ Previous bone fracture of any kind ☐ Drink more than 3 alcoholic drinks per day

☐ Previous use of steroid medication for more than 3 months ☐ Family history of osteoporosis

☐ History of rheumatoid arthritis Either parent fractured a hip ☐ Milk intolerance

☐ Celiac disease ☐ Menopause before age 45 ☐ Weight less than 130 lbs

Family History of Cancer

Type of Cancer	Relationship to you *(list all blood relatives, be specific)*	Age of onset	Still living?
Breast			
Ovary			
Uterus or cervix			
Bowel			
Other			