



ANNUAL WOMEN'S HEALTH QUESTIONNAIRE

Name:
UIN:
Birth date:
Date:

A. MENSTRUAL HISTORY

Age of first period
Periods usually come every
First day of last period
Was last period normal in length and flow?
Do you have cramps with periods?
Do you take any medication for cramps?
Number of pads/tampons used on heaviest day:
Do you have bleeding between periods?
If yes, explain:

B. CONTRACEPTIVE HISTORY

Not applicable (move to section C)
Have you ever used any of the following?
Barrier method:
Hormonal:
IUD:
What is your current method of birth control?
Have you had sex without using birth control since your last menstrual period?

C. GYNECOLOGIC HISTORY

Have you ever had a pelvic exam?
Did this include a Pap Smear?
Have you ever had an abnormal Pap Smear?
Have you been taught how to do a SELF breast exam?
Do you do a SELF breast exam?
Have you completed the HPV vaccine series?
Have you ever had any of the following?
Pain with intercourse
Breast abnormalities
Vaginal infections (BV, yeast)
Urinary tract infections/UTIs (frequency/most recent)
Abnormal hair growth (face, chest, abdomen)
Endometriosis
Ovarian Cysts/Polycystic Ovarian Syndrome
HPV/Genital warts
Uterine fibroids
Pelvic Inflammatory Disease
Acne
Other

D. PREGNANCY HISTORY

Have you ever been pregnant?
If Yes, # of pregnancies
Age at first pregnancy
Outcome: Birth, Elective Abortion, Miscarriage, Tubal/Ectopic
Comments:

Patient Signature:
Date:
Clinician Comments:
Clinician Signature:
Date: