Women's Health Questionnaire

Name: ______________________________________Date: ________ Birth date: ____________

Allergies: (food, medication, other): ____

Who is your family doctor: ____

First day of last menstrual period: ______________

What age did you start your Periods? ___________

Are your period's normal? Y N

If no, explain: ____

How long do your periods last? _______________

How far apart are your periods? _______________

Do you experience any pain? If yes, when? ____

Are you currently sexually active? Y N

Are you using Birth Control? Y N

If yes, what Type_____________________________

Date of last Pap test: _________________________

Have you ever had an abnormal pap test? Y N

Please explain:

____

Date of last mammogram? ____________________________

Have you ever had an abnormal mammogram? ____

How many times have you been pregnant? _________ How many children do you have? ______

Have you ever had any miscarriages or abortions? ______________________________________

Date of last Bone density test: (Age 65 +) _____________________

Date of last colonoscopy (50+): _____________________________

Results: ____