Atrius Health
Part of Optum®

INITIAL WOMEN'S HEALTH ASSESSMENT

Please fill out this questionnaire as completely as possible. The information provided will become part of your medical record and is totally confidential. This information will assist us in our effort to provide quality health care.

Name: _____ Preferred Name: _____
(Last) (First) (Middle Initial)

Today's Date: _____DOB: _____ Marital Status: _____ Occupation: _____

What would you like to address in today's visit? _____
_____

LIFESTYLE/RISK ASSESMENT:

SMOKING, ALCOHOL, DRUGS, ABUSE

Do you currently smoke cigarettes? □ no, never □ have exposure to second hand smoke

□ yes Date Started: _____ Amt/PPD: _____ □ quit Date Stopped: _____

How many alcoholic drinks do you have in an average week? □ none # _____

Do you ever drink more than 3 at one sitting? □ no □ yes_____ Have you ever used IV drugs? □ no □ yes

What recreational drugs have you used? □ none □ marijuana □ heroin □ crack □ cocaine □painkillers □ other _____

Have you ever been physically or emotionally abused? □ no □ yes

Do you have a history of alcohol or drug addiction? □ no □ yes

EXERCISE & DIET

Do you exercise and if so, how often? □ regularly □ occasionally □ rarely □ never

What type of exercise: _____

Do you have any concerns about your weight? □ none □ gain □ loss

Do you have any concerns about what you eat: □ no □ yes

How many different types of fruits and vegetables do you have in your house right now: 0-3____ 4-8____ 9 or more___

Do you regularly have dairy in your diet (yogurt, cheese, milk, etc) □ no □ yes

SEXUAL HISTORY

Have you ever had sex or been sexually active? □ no □ yes If yes, are you currently having sex? □ no □ yes

Do your partner(s) have a □ penis □ vagina (*check all that apply*)

Have you or your partner(s) had new sexual partners since your last STD/STI test? □ no □ yes

Do you have concerns about sexually transmitted infections? □ no □ yes □ unsure

Do you have any concerns about sex or your sexual health? □ no □ yes

Do you have any concerns about vaginal dryness or pain with intercourse? □ no □ yes

Do you have any concerns about libido? □ no □ yes

Are you planning a pregnancy ? □ now □ in future □ never □ unsure

If at risk for unplanned pregnancy, what method of birth control are you using? _____

SAFETY

Do you use sunscreen regularly? □ no □ yes

Do you use a seatbelt? □ no □ yes

Have you recently felt down, hopeless or had little interest in doing things you used to enjoy? □ no □ yes

Have you been emotionally or physically abused by your partner or someone close to you? □ no □ yes

Have you ever experienced unwanted sexual touching and/or contact? □ no □ yes

Is there anything in your past that might make your visits with us scary, uncomfortable or traumatic? □ no □ yes

How would you describe your relationship with your partner? □a lot of tension □some tension □no tension □N/A

Do you and your partner work out arguments with □great difficulty □ some difficulty □no difficulty □N/A

ALLERGIES:

Please note any allergies/ reactions to medications or other agents. □ **None**

Allergen and reaction:

_____

_____

CURRENT MEDICATIONS/SUPPLEMENTS/VITAMINS: □ None *Use back for more; If you would like a list of current medications in your medical record, please ask Medical Assistant to provide.*

Med/Dose/Instr: _____

Med/Dose/Instr: _____

Med/Dose/Instr: _____

IMMUNIZATIONS:

Have you obtained a Tdap immunization (tetanus, diphtheria, pertussis)?	□ no	□ yes	□ don't know
Have you been vaccinated against the HPV virus?	□ no	□ yes	□ don't know
Have you had a flu shot this season?	□ no	□ yes	□ don't know

OBSTETRICAL HISTORY:

Have you ever been pregnant? □ no □ yes If yes, how many times have you been pregnant? _____

What age where you: 1st pregnancy_____ 1st live birth_____ How many total months have you breastfed?_____

How many children do you have? _____ **Please list all pregnancies (including miscarriages and abortions):**

Pregnancy Outcome (vaginal del, C-section, VBAC, miscarriage, ectopic, induced abortion)	Date (or Year if unsure)	How far along were you?	Problems or Complications

MENSTRUAL HISTORY and STATUS:

At what age did your periods start?_____ If post-menopausal at what age did your periods stop? _____**If pre-menopausal:** Date of Last Menstrual Period:_____

In the past were your periods □ mostly regular □ mostly irregular, when not on the birth control pill

Do you have any concerns about your menstrual cycle:_____

Are your periods currently: □Regular □ Irregular

Is your Flow: □ light □ moderate □ heavy

How often do you have periods: _____

How many days do your periods last? _____

Do you have spotting or bleeding between periods?□ no □ yes

Do you have menstrual pain/cramping? □no □mild □moderate □severe

What medications do you take for this? _____ _____

If post-menopausal:

Are you experiencing any vaginal bleeding? □ no □ yes

Did you use hormones?

□ no □ yes

If yes:

Oral/Patch □ current □ past

Vaginal □ current □ past

GYNECOLOGIC HISTORY

Check if you have had any of the following: □ **None**

- □ Abnormal Pap Test
- □ Breast Biopsy
- □ DES Exposure in Utero (when your mother was pregnant with you)
- □ Pain with sex (dyspareunia)
- □ Endometriosis or Adenomyosis
- □ Fibroids, uterine
- □ Infertility
- □ Ovarian Cyst,Type:_____
- □ Chronic Pelvic Pain
- □ Pelvic Inflammatory Disease (PID)
- □ PMS
- □ STI/Sexually Transmitted Infections
  - □ Chlamydia
  - □ Genital Herpes
  - □ Gonorrhea
  - □ Genital Warts
  - □ Hepatitis B
  - □ Hepatitis C
  - □ HIV/AIDs
  - □ Syphilis
  - □ Abnormal Uterine Structure (Uterine Anomaly)
- □ Urinary Incontinence
- □ Vaginal dysplasia (precancer)
- □ Vulvar dysplasia (precancer)
- □ Vulvar Pain/Vulvodynia
- □ Recurrent Vaginitis
- □ Yeast
- □ BV
- □ Other_____

MEDICAL HISTORY:

Check if you have ever had or been diagnosed with: □ **None**

- □ Anemia
  - □ Sickle Cell
  - □ Thalassemia
- □ Arthritis
- □ Asthma
- □ Cancer: _____
- □ Cerebrovascular disease (stroke/TIA)
- □ Chickenpox
- □ CAD/Heart Attack/Angina
- □ Bleeding tendency (coagulation defect)
- □ Depression
- □ Diabetes
  - □ Only In pregnancy
- □ Endocrine Problem
  - □ Thyroid
  - □ Polycystic ovaries
  - □ Other
- □ Gastrointestinal Problem(s)
  - □ GERD
  - □ Other
- □ Gallbladder disease
- □ Headache (migraine)
- □ Heart Murmur
- □ Hepatitis/Jaundice
- □ HIV/AIDS
- □ Hyperlipidemia (high cholesterol)
- □ High blood pressure
- □ Inflammatory Bowel Disease
- □ Crohns
- □ Ulcerative Colitis
- □ Interstitial Cystitis
- □ Irritable Bowel
- □ Kidney problems
- □ Osteoporosis
- □ Seizure Disorder
- □ Substance abuse
  - □ Alcohol
  - □ Drugs
- □ Tuberculosis
- □ Thromboembolic disorder (blood clots in legs or lungs or a tendency to form clots)
- □ Urinary Tract Infection (UTI)
- □ Other:_____

SURGICAL HISTORY:

List all operations (*excluding* pregnancy): □ **None**

DATE	SURGERY

Have you had any problems with anesthesia? ?□ no □ yes:_____

FAMILY HISTORY: □ **Adopted**

Illness	**Relation to you**	**Note if relation is Paternal=P** *your father's side* **or Maternal= M** *your mother's side*	Details/Comments
Autoimmune Disease *(e.g., lupus, ulcerative colitis, rheumatoid arthritis)*			
CAD/Coronary Artery Disease *(e.g., Heart Disease/Heart Attack, High Blood Pressure, High Cholesterol)*			
Cancer - Melanoma			
Cancer – Endometrial/Uterine			
Cancer - Breast			
Cancer - Colon			
Cancer - Ovarian			
Diabetes			
Genetic Disorders *(e.g., Muscular Dystrophy, Tay Sachs, Fragile X Thalassemia, sickle cell)*			
Gynecologic Problem *(e.g., fibroids, infertility, early menopause, endometriosis)*			
Hypercoagulation Disorder *(blood clots in legs or lungs)*			
Mental Health Concerns (*e.g., anxiety, depression, bipolar disorder, etc.)*			
Osteoporosis or Hip Fracture			
Stroke			
Thyroid Disease			
Substance Abuse			
Other			

REVIEW OF SYSTEMS*: Check if you currently have problems with:*

- ☐ fatigue
- ☐ weight loss
- ☐ weight gain
- ☐ easy bruising
- ☐ enlarged glands or lumps
- ☐ environmental allergies
- ☐ hot flashes
- ☐ heat or cold intolerance
- ☐ excess hair growth
- ☐ excessive hair loss
- ☐ skin rash
- ☐ changing moles
- ☐ chest pain
- ☐ persistent cough
- ☐ shortness of breath
- ☐ wheezing
- ☐ difficulty breathing
- ☐ indigestion or nausea
- ☐ abdominal pain
- ☐ abdominal bloating
- ☐ constipation
- ☐ diarrhea
- ☐ painful urination
- ☐ involuntary loss of urine
- ☐ abnormal vaginal discharge
- ☐ headaches
- ☐ fainting
- ☐ dizziness/balance
- ☐ anxiety
- ☐ depression
- ☐ memory loss
- ☐ trouble sleeping
- ☐ varicose veins
- ☐ muscle or joint pain
- ☐ back pain
- ☐ breast pain
- ☐ breast discharge
- ☐ breast lump
- ☐ Other_____

Please note any particular stresses in your life or anything else you think we should know:

Signature: _____ Date: _____

If your Primary Care Physician (PCP) is not an Atrius physician please tell us:

PCP Name, Address: _____

☐ **I do not have a PCP**

Who Referred You:

☐ **PCP**

☐ **Other, Name and Address:** _____

Do you want a copy of today's visit to be sent to your:

	YES	NO	N/A
PCP	☐	☐	
Referring Clinician	☐	☐	☐

Revised: 8/10/23