



### 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

#### **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 \_\_\_\_\_

#### **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 HVMA 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 were 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:**

<p>At what age did your periods start?_____ If post-menopausal at what age did your periods stop? _____ <b>If pre-menopausal:</b> Date of Last Menstrual Period:_____</p> <p>In the past were your periods <input type="checkbox"/> mostly regular <input type="checkbox"/> mostly irregular, when not on the birth control pill</p> <p>Do you have any concerns about your menstrual cycle:_____</p> <p>Are your periods currently: <input type="checkbox"/> Regular <input type="checkbox"/> Irregular</p> <p>Is your Flow: <input type="checkbox"/> light <input type="checkbox"/> moderate <input type="checkbox"/> heavy</p> <p>How often do you have periods: _____</p> <p>How many days do your periods last? _____</p> <p>Do you have spotting or bleeding between periods?<input type="checkbox"/> no <input type="checkbox"/> yes</p> <p>Do you have menstrual pain/cramping? <input type="checkbox"/> no <input type="checkbox"/> mild <input type="checkbox"/> moderate <input type="checkbox"/> severe</p> <p>What medications do you take for this? _____</p>	<p><b>If post-menopausal:</b></p> <p>Are you experiencing any vaginal bleeding? <input type="checkbox"/> no <input type="checkbox"/> yes</p> <p>Did you use hormones? <input type="checkbox"/> no <input type="checkbox"/> yes</p> <p>If yes: Oral/Patch <input type="checkbox"/> current <input type="checkbox"/> past Vaginal <input type="checkbox"/> current <input type="checkbox"/> past</p>
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**GYNECOLOGIC HISTORY**

Check if you have had any of the following:  None

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

**MEDICAL HISTORY:**

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

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

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

Revised: 2/3/20