Atrius Health

PERIODIC 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_____

What recreational drugs are you currently using? ☐none ☐ marijuana ☐ heroin ☐crack ☐cocaine ☐painkillers ☐other ____

Have you 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? _____

ALLERGIES:

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

Allergen and reaction:

_____

_____

CURRENT MEDICATIONS/SUPPLEMENTS/VITAMINS: ☐ None *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 year ? □no □yes □don't know

MENSTRUAL STATUS:

If pre-menopausal: Date of your last Menstrual Period:_____

Do you have any concerns about your menstrual cycle:_____

Are your periods currently: θRegular □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? θno θmild θmoderate θsevere

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
- □ 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
- □ 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 /SURGICAL HISTORY:

Since your last exam here, have you had any major health problems or surgery? □no □yes**, explain:**

FAMILY HISTORY: Please note any changes in the health of your family since your last visit: □None

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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
- □ 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 other stresses or anything else you think we should know:

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

- □ Check box if you would like us to send a copy of your visit note to your PCP

Signature: _____ Date: _____