Well Woman Questionnaire

1. Date your last period began: ____________________
2. Age when you had your first period? __________
3. Periods come every _______ days and last for _______ days.
4. Are your periods regular? □ Yes □ No, Explain___________________________________________
5. Any problems with your periods? _______________________________________________________
6. Have you ever been pregnant? □ Yes □ No
   How many live births? _____  Miscarriages? _____  Terminations? _____
7. Date of Last Pap smear? ___________ Any history of abnormal pap?_________________________
8. Have you had a colposcopy or treatment for abnormal pap? _________________________________
9. Are you sexual active? □ Yes □ No
10. Are you currently using contraception? _____  If yes, what type ______________________________
11. Have you used contraception in the past? _____  If yes, what type ______________________________
12. Condom usage: Always□ Inconsistent□ Never □ N/A □
13. Do you perform self-breast exams? __________ and how often ______________________________
14. Is there a family history of breast cancer? □ Yes □ No Who ______________________________
15. Is there a family history of ovarian cancer? □ Yes □ No Who ______________________________
16. Is there a family history of colon cancer? □ Yes □ No Who ______________________________
17. Is there a family history of uterine cancer? □ Yes □ No Who ______________________________
18. Do you currently have any of the following symptoms
   Urinary symptoms □ Yes □ No ____________________________
   Abdominal or Pelvic Pain □ Yes □ No ______________________
   Back pain □ Yes □ No _________________________________
   Groin or pubic lesions □ Yes □ No _______________________
   Lymph node swelling or pain □ Yes □ No __________________
   Vulvar discomfort □ Yes □ No ____________________________
   Vulvar lesions □ Yes □ No _____________________________
   Vaginal pain □ Yes □ No ________________________________
   Vaginal itching □ Yes □ No ______________________________
   Vaginal discharge □ Yes □ No ____________________________
   Genital odor □ Yes □ No ________________________________
   Painful intercourse □ Yes □ No __________________________
   Any history of forced/coerced sexual contact □ Yes □ No ___________
   Any self-treatment performed? ________________________________
19. Have you ever been tested for the following STI’s (sexually transmitted infections) If so, when and what were the results:

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<tr>
<th>STI</th>
<th>Date: ______</th>
<th>Results: ______</th>
<th>Treatment: __________________</th>
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<tbody>
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<td>Gonorrhea</td>
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20. **Risk Factor Assessment** (per CDC guidelines)

- Inconsistent condom usage
- Sexual contact associated with substance abuse
- Anonymous sexual partner(s)
- Multiple sexual partner(s) (> 1 per yr)
- Sexual contact with known positive HIV partner(s)
- IV drug use by patient or partner
- Forced/coerced sexual contact
- History of blood transfusion
- History of tattoo
- History of body piercing
- History of shared razors