Saint John's Health Center
PROVIDENCE Health & Services

WOMEN'S HEALTH QUESTIONAIRE

The following questions will help us determine what problems you have and what needs to be done prior, during or after your visit. Please complete this at least 3 days before the visit and email or fax it back to the Doctor's office. Please fill in all **six** pages. It is long because it is comprehensive. We really want to know you well so we can properly care for you. If you cannot remember specific details, please provide your best guess. If you are uncomfortable with any question, do not answer it. Thank-you!

1. **Who referred you to my practice? (Circle one)**
   Patient Family member Physician Name?
   _____
2. **What is the main reason for today's visit?**
   _____
3. **Do you have any other concerns?**
   _____

What are your health goals for the next year? _____

How would you rate your health? (circle one): Excellent / Good / Fair / Poor

Please list healthcare providers you see regularly as well as their specialty:

Name	**Specialty**	**Number**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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WOMEN'S HEALTH HISTORY

Total number of pregnancies: _____ # of births: _____ # of miscarriages: _____ # of abortions: _____
Age at beginning of periods (menstruation): _____
Age at end of periods (menopause/hysterectomy): _____ □ Not applicable
Do you have concerns about your periods or menopause you'd like to discuss? □ No □ Yes
If you are having periods, how often do they occur? Every _____ days. How long do they last? _____ days.

Urologic Symptoms

The following questions are related to your bladder symptoms or pelvic/vaginal pressure, and its impact upon you.

1. Overall, how frustrated are you with your bladder control:
   □ Not at all □ Slightly □ Somewhat □ Moderately □ Greatly

2. How much has this problem affected your emotional health: (depressed mood, nervousness, unwilling to leave the house, etc.)
   □ Not at all □ Slightly □ Somewhat □ Moderately □ Greatly

3. How has your bladder problem affected your ability to exercise or work?
   □ Not at all □ Slightly □ Somewhat □ Moderately □ Greatly

4. Do you feel that you empty your bladder completely after voiding? If not, how much does it bother you?
   □ Not at all □ Slightly □ Somewhat □ Moderately □ Greatly

5. How frequently do you usually need to go to the bathroom to urinate during the day?
   □ Every hour □ Two hours □ Three hours □ Four hours □ More than four

6. If you do go to the restroom frequently, how much does it bother you?
   □ Not at all □ Slightly □ Somewhat □ Moderately □ Greatly

7. When you need to use the restroom, do you often need to hurry or can you take your time and go when you want to? □ Hurry □ Take time

8. If you have a strong urge to urinate, could you possibly leak prior to reaching the restroom?
   □ Yes □ No
   a. How much does it bother you?
      □ Not at all □ Slightly □ Somewhat □ Moderately □ Greatly

9. How many times do you need to get up during the night to go to the bathroom?
   □ 0-1 □ 2-3 □ 4-5 □ 6+

10. How bothered are you by urine leakage related to physical activity?
    □ Not at all □ Slightly □ Somewhat □ Moderately □ Greatly

    a. Check all activities which result in accidental leakage:
       □ Coughing □ Sneezing □ Jumping
       □ Lauging □ Exercising □ Bending

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11. Do you have more bladder infections than you believe you should □ Yes □ No

Pelvic Floor Questions:

12. Do you have any pain or pressure in the lower abdomen or genital area, and if so, how much does it bother you?
□ Not at all □ Slightly □ Somewhat □ Moderately □ Greatly

13. How much does your uncontrolled leakage of urine or vaginal pro-lapse affect your sex life?
□ Not at all □ Slightly □ Somewhat □ Moderately □ Greatly

14. Do you or your partner feel that your vagina is "too loose" for enjoyable intercourse?
□ Yes □ No

Bowel Symptoms:

15. Do you have any uncontrollable escape of gas? □ Yes □ No
16. Do you have any uncontrollable escape of stool? □ Yes □ No
17. Do you feel that you need to strain excessively to have a bowel movement?
□ Yes □ No
18. Do you feel that you are not able to empty your bowels at the end of a BM?
□ Yes □ No
19. Do you have pain in your bladder?
□ Yes □ No

Diet and Lifestyle Assesment

Smoking History

1. Do you currently smoke? Y N
(If you have never used any tobacco, skip to Alcohol Use section below)
   a. Approximately how many packs/day do you smoke? _____
2. Have you smoked in the past?
   a. If yes, when did you quit?
   _____
   b. Approximately how many packs/day did you smoke? _____
3. Are you exposed to 2nd hand smoke? Y N

Alcohol Use

4. Do you drink alcohol? Y N
   a. # of drinks/week: _____ □ Beer □ Wine □ Liquor
   b. How many times in a year have you had >3 drinks (for women) >4 drinks (for men) in a day?
   _____

Drug Use

5. Have you **ever** used recreational drugs? Y N
   a. If yes, which ones? _____
   b. Quit which ones? □ All _____
   c. Any used currently? _____

Safety

6. Does your home have a working smoke detector? Y N
7. Do you have guns in your home? Y N
   a. If yes, are they locked up & ammo stored separately? Y N
8. Are you or have you been exposed to toxic chemicals at work/hobbies? Y N
9. Do you use a helmet for recreational activities? (e.g. bike, skateboard, ski) Y N
10. Do you use seatbelts consistently? Y N
11. Have you or any family member ever been hurt/insulted/threatened? Y N

Diet

12. Do you follow any specific diet? Vegan Gluten-free Other_____

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13. Do you consider yourself in shape? Y N
14. Do you exercise regularly? Y N
    a. If yes, what type(s) and how often?

    _____
15. Do you have any injuries or pain that limit activity? Y N
16. Have you ever had a bone density scan done for osteoporosis? Y N

Cardiac Health Assessmet

1. Do you have a cardiologist? Y N
    a. If yes please provide their name and number:

    _____
2. Have you had an EKG in the last year? Y N
3. When was your cholesterol last checked?

    _____
4. Do you have the results? Y N
    a. If Yes: Total Cholesterol: _____
    LDL: _____
    HDL: _____
5. Have you had a cardiac stress test ever? Y N
    a. If yes, when? _____
    b. What were the results? Normal Other:

    _____
6. Have you had a carotid duplex? Y N
7. Have you had a cardiac calcium scan? Y N

Cancer Screening

Breast CA:

1. Last mammogram? _____
2. Results: _____
3. Have you ever undergone a breast biopsy? Y N

Lung CA:

1. Do you have a smoking history of more than 30 pack years? Y N
2. Have you undergone a CT of the chest in the last year? Y N

Colorectal CA:

1. Do you have a personal or family history of colon cancer? Y N
2. Have you ever had a colonoscopy?
    a. If yes, when? _____
    b. Any abnormalities? Y N
3. Any history of inflammatory bowel disease? Y N

Skin CA:

1. Do you have daily sun exposure? Y N
2. Do you have a dermatologist? Y N
3. Do you normally wear sun protection? Y N
4. When was your last skin exam? _____

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Psychiatric Risk Assessment

Over the last 2 weeks have you had any of the following:

1a. Feeling nervous, anxious, or on edge? (circle one)
No days (0), Several days (1), 7 or more days (2), Nearly everyday (3) _____

1b. Not being able to stop or control worrying? _____
No days (0), Several days (1), 7 or more days (2), Nearly everyday (3)

Total Score: _____

2a. Little interest or pleasure in doing things?
No days (0), Several days (1), 7 or more days (2), Nearly everyday (3) _____

2b. Feeling down, depressed or hopeless? _____
No days (0), Several days (1), 7 or more days (2), Nearly everyday (3)

Total Score: _____

3. In the past year have you had more than 5 drinks in one day? Y N

MEDICATIONS: Please list (or show us your own printed record) **all** prescriptions and non-prescription medications. This includes vitamins, herbs, supplements, home remedies, birth control pills, inhalers, over the counter pain pills (Advil, Aleve, Tylenol, etc).

□ Check box if you do not take any prescription or over the counter medications.
□ Check box if you brought a list of your medications (give it to my assistant and don't write in medications below).

Medication Name	Dose (e.g. mg/pill)	How many times per day?

ALLERGIES or intolerance to medications? □ NONE
(If yes, to what & what reaction?)

_____

IMMUNIZATIONS: Enter year (if known) of any vaccinations you have had.
Tetanus (Td) _____ With Pertussis (Tdap) _____ Varicella (Chicken Pox) shot *or* illness _____
Pneumovax (pneumonia) _____ Influenza (flu shot) _____ Hepatitis A _____ Hepatitis B _____ MMR _____
Meningitis _____ Zostavax (shingles) _____ HPV _____

PERSONAL MEDICAL HISTORY:
□ Check box if you have no history of significant medical illnesses.

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WOMEN'S HEALTH QUESTIONAIRE

Do you currently have or have you had (in the past) any of the following conditions?

Condition	***Now***	***Past***	***Comments***
Alcohol / Drug abuse			
Allergy (Hay Fever)			
Anemia			
Anxiety			
Arthritis (Rheumatoid)			
Arthritis (Osteoarthritis)			
Asthma			
Bladder / Kidney Problems			
Blood Clot (leg)			
Blood Clot (lung)			
Blood Transfusion			
Breast Lump (benign)			
Cancer Breast			
Cancer Colon			
Cancer Other Type			
Cancer Ovarian			
Cancer Prostate			
Cataracts			
Chicken Pox			
Colon Polyp			
Coronary Artery Disease			
Depression			
Diabetes (adult onset)			
Diabetes (childhood onset)			
Diverticulosis			
Emphysema (COPD)			
Fractures (broken bones)			
Where?			
Gallbladder Disease			
Gastroesophageal Reflux (Heartburn/GERD)			

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Glaucoma			
Gout			
Gynecological Conditions (Endometriosis)			
Gynecological Conditions (Fibroids)			
Gynecological Conditions (Other)			
Heart Attack			
Hepatitis – Type A			
Hepatitis – Type B			
Hepatitis – Type C			
Hepatitis – Other			
High Blood Pressure			
High Cholesterol			
Hip Fracture			
Irritable Bowel Syndrome			
Kidney Disease / Failure			
Kidney Stones			
Liver Disease			
Migraine Headaches			
Osteoporosis			
Pneumonia			
Prostate (enlargement)			
Prostate (nodules)			
Seizure / Epilepsy			
Skin Condition (Eczema)			
Skin Condition (Psoriasis)			
Skin Condition (Abnormal Moles)			
Sleep Apnea			
Stomach Ulcer			
Stroke			
Thyroid (Nodule)			
Thyroid High (Overactive) / Hyperthyroidism			
Thyroid Low (Underactive) / Hypothyroidism			

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Other (list)			
Other (list)			

SURGICAL & PROCEDURE HISTORY –
□ Check box if you have never had any medical procedures or surgeries.
Please check off any procedure or surgeries. List any abnormal finding, details or complications under comments.

Surgical Procedure	***Year***	***Comments***
Abdominal surgery		
Angiogram (heart)		
Angiogram (vascular)		
Appendectomy (appendix removal)		
Back surgery (lumbar)		
Biopsy (location in comments)		
Breast Biopsy		
Circle: Right Left Both		
Breast surgery		
Circle: Right Left Both		
Cataract surgery		
Colonoscopy		
Coronary Bypass		
Coronary Stent		
C-Section		
Echocardiogram (heart)		
EGD (Stomach Endoscopy)		
Gallbladder Removal		
Circle: Laparoscopic (HX0271)		
Heart Surgery (other)		
Hip Surgery		
Circle: Right Left Both		
Hysterectomy (partial, ovaries left)		
Circle: Laparoscopic Vaginal Abdominal		
Hysterectomy (including ovaries)		
Circle: Laparoscopic Vaginal Abdominal		

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Knee Surgery		
Circle: Right Left Both		
LEEP (Cervix surgery)		
Neck (Spine) surgery		
Ovary Removal		
Circle: Right Left Both		
Pulmonary Function Test		
Sigmoidoscopy		
Sinus Surgery		
Stress Test (stress echo)		
Stress Test (thallium/perfusion)		
Stress Test (treadmill)		
Tonsillectomy		
Tubal ligation		
Vasectomy		
Other (list)		

FAMILY HISTORY

Adopted? □ No □ Yes. If adopted and you do not know your family history skip the Family History section. Indicate which relative has had the following diseases (parents, brothers & sisters are the most important). Write in number of siblings in appropriate boxes.* If some siblings are alive and some are deceased use the space to the right to explain further.

	Mother	***Father***	***Sisters***	***Brothers***	***Mom's Mom***	***Mom's Dad***	***Dad's Mom***	***Dad's Dad***	***Other Blood Relatives***
Alive									
Age currently or at death									
Diseases & Conditions									
No significant history known									
Hypertension – high blood pressure									
Hyperlipidemia – high cholesterol									
Heart Attack, Angina									

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Diabetes Type II (adult onset)									
Cancer, Breast									
Cancer, Colon									
Cancer, Prostate									
Osteoporosis									
Depression									
Alcoholism / Drug abuse									
Alzheimers									
Asthma									
Autoimmune Disease									
Bleeding or Clotting Disorder									
Cancer, Lung									
Cancer, Ovarian									
Cancer, Other type									
Colon Polyp									
Diabetes Type I (childhood onset)									
Emphysema (COPD)									
Genetic Disorder (explain)									
Glaucoma									
Heart Disease (CHF)									
Heart Disease (Other)									
Hepatitis B or C									
Hip Fracture									
Hypothyroidism / Thyroid Disease									
Kidney Disease									
Kidney Stones									
Macular Degeneration									
Stroke									
Sudden Cardiac Death									

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SOCIOECONOMIC:
Occupation (or prior occupation):
_____
Employer:
_____
_____
Are you: □ Retired □ Unemployed □ On a leave of absence □ Disabled □ Homemaker □ Other
_____
Marital status: □ Single □ Partner □ Married □ Divorced □ Widowed
Spouse/partner's name:
_____
_____
Number of children: _____ Ages (if minors): _____ # of grandchildren: _____
Education: □ High school or GED □ Trade school □ College □ Graduate school □ Other _____

MEDICAL FORMS:
Please check any of the following forms you have completed:
□ Advance Directive for Health Care (ADHC)
□ Durable Power of Attorney (DPA) for healthcare decisions
□ Living Will
□ POLST (Physician Orders for Life Sustaining Therapy)
□ Know about these or have the forms but have not completed them
□ Don't know what these are

REVIEW OF SYSTEMS Do you currently have any of the following problems?
Please check all that apply to you. If none apply, please leave blank.

CONSTITUTIONAL □ Weight loss □ Weight gain □ Fever □ Fatigue □ Chills □ Other

EYES □ Double vision □ Spots before eyes □ Vision changes □ Other

ENT MOUTH □ Earaches □ Ringing in ears □ Sinus problems □ Headaches □ Mouth sores
□ Sore throat □ Dental problems □ Rhinorrea □ Nasal bleeding □ Other

CARDIOVASCULAR □ Chest pain □ Heart palpitations □ Painful breathing □ Swelling □ Other

RESPIRATORY □ Wheezing □ Shortness of breath □ Chronic cough □ Phlegm production □ Hemoptysis □ Other

GASTROINTESTINAL □ Diarrhea □ Abdominal Pain □ Constipation □ Bloody stool □ Cramping
□ Nausea/vomiting □ Hematochezia □ Hematemesis □ Other

URINARY □ Blood in urine □ Pain with urination □ Urinary frequency □ Urgency
□ Incomplete emptying □ Leak urine with coughing □ Other

GENITAL □ Painful periods □ Painful intercourse □ Irregular periods □ Vaginal discharge
□ Very heavy periods □ Other

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MUSCULOSKELETAL □ Bone pain □ Muscle weakness □ Muscle pain □ Change in strength □ Joint pain □ Change in range of motion □ Other

SKIN BREAST □ Pain in breast □ Breast discharge □ Breast mass □ Rash □ Other

NEUROLOGICAL □ Dizziness □ Seizures □ Numbness □ Difficulty Walking □ Headache □ Other □ Spine injury □ Back injury/pain □ Radiculopathy

PSYCHIATRIC □ Depression □ Suicidal ideation □ Psychosis □ Anxiety □ Other

ENDOCRINE □ Hot flashes □ Abnormal thirst □ Increase facial/body hair □ Other

HEMATOLOGIC □ Frequent bruising □ Enlarged lymph node □ Bleeding problems □ Lymphedema □ Other

ALLERGY/IMMUNLOGY □ Allergies □ Drugs □ Other

Thank you for taking the time to complete this form!