Annual Questionnaire for Women

If you are uncomfortable with any question, please feel free to leave it blank.

Date:_____ **Name**_____

Blood pressure:_____/_____ **Pulse:** _____ **Weight:**_____ **Height:**_____

What concerns are you hoping to discuss at your annual visit?

_____

_____

What new medical problems, medicines or medicine allergies have you had since your last visit?

_____

_____

Have you seen other doctors or been to the Emergency room this year?

_____

Are you concerned that your medicines are making you ill? Yes No Maybe N/A
Are you confident in managing your health problems? Yes No Maybe N/A

Your exercise habits:

What do you do for exercise?

_____

How often?_____

For how much time?_____

Any troubles when exercising? *please circle*
chest pain, dizziness, fainting,
shortness of breath,
other pain or injuries

Are you working to change your weight? Yes No

If yes, how:_____

Your diet:

How many servings do you get each day of

____High calcium food

____Fruit

____Vegetables

____High fiber carbohydrate

Do you eat breakfast?_____

Other habits that protect your health:

Do you wear your seatbelt?..... Yes No
Do you have working smoke detectors?..... Yes No
Do you wear sunscreen?..... Yes No N/A
Do you use hearing protection around loud noises?..... Yes No N/A
Do you brush and floss your teeth daily?..... Yes No N/A
Have you had a dental cleaning in the last year?..... Yes No N/A
Do you have grab bars in the bath and handrails on stairs? Yes No
Do you have well lit and cleared pathways in your home? Yes No
If you keep guns are they secured and unloaded?..... Yes No N/A

Potential Health Hazards:

How much caffeine do you use daily? _____

Do you smoke or chew tobacco? ____ If yes, how much? _____

If so, do you plan to quit? _____ When? _____

Do you consume alcohol?_____ If yes, how much?_____

Do you feel you should cut down? Yes No N/A
Have others recommended you cut down? Yes No N/A
Do you ever drink before driving? Yes No N/A

Do you use any other drugs like marijuana, crack/cocaine, narcotics, heroin, MDMA, others?

Date:_____ **Name**_____

Gynecology:

Are your periods regular? _____ Date of last period?_____
Do you spot in between? _____
Have you had any bleeding since menopause?_____
How many sexual partners have you had in the last year: none one 2-5 more than 5?
male female both?
Are you having troubles with sex: pain or change in desire or other issues?_____
What do you do for birth control: no sex, menopause, hoping to get pregnant, condoms, vasectomy, tubal, pills, patch , ring, IUD, fertility awareness, pulling out, diaphragm, spermicide, hysterectomy, female partner infertility,other?
Do you use condoms to protect yourself from sexually transmitted diseases? Yes No N/A
Are you having menopausal symptoms: hot flashes, vaginal dryness, trouble sleeping, other?

Have you had any of these problems: *please circle all that apply*

Blood in urine	Cough
Trouble with urine leaking	Shortness of breath
Unexplained frequent urination	Chest pains
Increase in night time urination	Swelling of hands or feet
Change in bowel habits	Leg pain when you walk up stairs or hills
Blood in stool	Hoarseness
Trouble with your memory	New or changed moles or other skin changes
Any falls	Unexplained lump
Head aches	Unexplained weight loss
Vision problems	Unexplained bruising or bleeding
Trouble hearing	Fatigue
Difficulty sleeping	Unexplained thirst
Trouble swallowing	Snoring

Spells of weakness, inability to speak or face drooping
Pain that interferes with your ability to do your every day activities
Trouble doing your daily activities: cooking, laundry, housework, using the phone, managing money, managing medicines, driving, other:

Mental Health:

Have you been feeling down, depressed or hopeless?	Yes	No
Have you felt little interest in doing things?	Yes	No
Are you often anxious?	Yes	No
Do you get premenstrual mood changes (PMS)?	Yes	No
Is someone at home abusing alcohol or drugs?	Yes	No
Do you feel unsafe in your home?	Yes	No
Are you threatened, pushed or hit?	Yes	No
Are you having trouble solving family conflicts?	Yes	No
Are you having troubles at work?	Yes	No
Is your work damaging your health?	Yes	No
Do you have a lot of stress in your life?	Yes	No

How do you relieve stress? _____
_____
Does stress, anxiety or depression interfere with you ability to do everyday activities?_____

Do you have a Living Will, Advanced Directives or a Health Care Proxy?_____