9. Do you drink alcohol? □ YES □ NO

If yes:

a. Have you ever felt you should cut down on your drinking? □ YES □ NO

b. Have people ever annoyed you by nagging you about your drinking? □ YES □ NO

c. Have you ever felt guilty about your drinking? □ YES □ NO

d. Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover? □ YES □ NO

10. Prevention:

a. Which of the following are included in your diet:

| | | | |
|---|---|---|---|
| Grains and starches | □ a lot | □ some | □ few |
| Vegetables | □ a lot | □ some | □ few |
| Dairy foods | □ a lot | □ some | □ few |
| Meats | □ a lot | □ some | □ few |
| Sweets | □ a lot | □ some | □ few |

b. Exercise:

Activity ______________________________________

Days per week _________

Time/duration __________minutes

Exertion: □ stroll □ mild □ heavy

c. Do you always wear seat belts? □ YES □ NO

d. If over 30 years old, have you had your cholesterol level checked in the past five years? □ N/A □ YES □ NO

e. Have you had a tetanus shot in the past 10 years? □ YES □ NO

f. Does your house have a working smoke detector? □ YES □ NO

g. Do you have firearms at home? □ YES □ NO

h. Have you ever had a mammogram? □ YES □ NO

If yes, date of last:_________ where:_____________________

Have you ever had any abnormal mammograms? □ N/A □ YES □ NO

If yes, date:__________problem:______________________

For abnormality, did you have any of the following:

Biopsy □ YES □ NO

Cyst fluid drained □ YES □ NO

Surgery □ YES □ NO

i. How many sexual partners have you had in the last 12 months? ____In your lifetime?____

j. When is the last time you had a dental check-up? _______

11. Please describe any concerns you have: _____________________

___________________________________________________________

___________________________________________________________

___________________________________________________________

___________________________________________________________

___________________________________________________________

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*Thank you for your help.*

Patient:________________________ Date:____________________
DOB:_____________

MOUNTAINSTAR
Lone Peak
Primary Care
*affiliated with St. Mark's Hospital*

## WELL-FEMALE EXAM HISTORY

To help your doctor during today's health exam, please complete items 1 through 11.

1. Age: _______

   First day of last menstrual period:___________

   First year of menstruation: _________

2. Number of times pregnant: ________

   Number of completed pregnancies: ________

   Date of last pregnancy: _________

   If you are under age 55, what method of birth control do you use? ___________________________________________

   If pills, what kind? _______________________________________

   How many years have you used the pills? ________

   Are you planning a pregnancy in the next 6-12 months? □ YES □ NO

3. If you are through menopause or over age 50, do you take any of the following pills?

   Calcium □ YES □ NO
   Vitamin D □ YES □ NO
   Estrogen (Premarin) □ YES □ NO
   Progesterone (Provera) □ YES □ NO

4. Have you had any of the following problems:

   a. Abnormal Pap smears □ YES □ NO
      If yes, date:_________ problem:____________________
      For abnormality, did you have any of the following done:
      Colposcopy □ YES □ NO
      Biopsies □ YES □ NO
      Surgery □ YES □ NO
   b. High blood pressure, heart disease or high cholesterol □ YES □ NO
   c. Migraine headaches, blood clot in legs or cancer □ YES □ NO
   d. Abdominal or pelvic surgery or special tests □ YES □ NO
      If yes, what:_______________________ when: __________

5. Do you have any of the following:

   a. Problems with present method of birth control □ YES □ NO
   b. Bleeding between periods or since periods stopped □ YES □ NO
   c. Pain with intercourse or periods □ YES □ NO
   d. Any problem with interest in or enjoying intercourse □ YES □ NO
   e. A new or enlarging lump in breast □ YES □ NO
   f. Change in size/firmness of stools □ YES □ NO
   g. Change in size/color of a mole □ YES □ NO
   h. Severe headaches □ YES □ NO
   i. Pain in the leg, chest, abdomen or joints □ YES □ NO
   j. Trouble falling or staying asleep □ YES □ NO
   k. Often feeling down, depressed or hopeless during the past month □ YES □ NO
   l. Often having little interest or pleasure in doing things during the past month □ YES □ NO
   m. Conflict in your family or relationships, sometimes handled by pushing, hitting or cruelty □ YES □ NO

6. Do you have a parent, brother or sister with a history of the following:

   a. Cancer of the breast, intestine or female organs □ YES □ NO
   b. Heart pain or heart attacks before the age of 55 □ YES □ NO

   If yes to a or b:
   Relation: ____________________ Type: ___________
   Relation: ____________________ Type: ___________

7. Osteoporosis (thin-bone) screening:

   a. Is there a history of any relatives stooping over or losing height as they got older, "thin bones," or hip fractures □ YES □ NO
      If yes, relation: ______________________________
   b. Have you had any of the following:
      Height loss □ YES □ NO
      Broken hip or wrist □ YES □ NO
      Bone-density test □ YES □ NO
   c. Do you take any of the following:
      Steroids (prednisone) □ YES □ NO
      Medication for thyroid, seizures or thin bones □ YES □ NO

8. Have you ever used tobacco? □ YES □ NO

   If yes:
   Average number of packs/day: ________
   Number of years smoked: _______
   Year quit: _______
   When are you planning to quit?
   □ now □ next 6 months □ sometime □ never

Form continues on next page ~