

# Women's Health Assessment

Date: \_\_\_\_\_ Reason for visit:  Routine Health Maintenance  
 Health Problem: \_\_\_\_\_

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Zip Code: \_\_\_\_\_ Home phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

Work phone: \_\_\_\_\_ e-mail address: \_\_\_\_\_

Please contact me by: (check all that apply)

home phone  cell phone  work phone  e-mail  mail

Occupation: \_\_\_\_\_ Number of years: \_\_\_\_\_ Hours worked per week: \_\_\_\_\_

Marital Status:  Single  Married  Separated  Divorced  Widowed

I live: (check all that apply)

alone  with my spouse  with my children, age's \_\_\_\_\_  with a friend

other household members: \_\_\_\_\_  Pets: \_\_\_\_\_

Type of home:  single family  condominium  apartment  duplex

Floor levels:  one floor  two floors  basement

Home safety:  smoke alarm  carbon monoxide detector  radon detector  escape plan  
 fire extinguisher  home security system

Exposure to hazardous material:  second hand smoke  asbestos  chemicals: \_\_\_\_\_  
 none to my knowledge  other: \_\_\_\_\_

Personal safety:

I use my seat belt  always  sometimes  never

My automobile has an air bag  Yes  No  Unsure

I have a history of falls  Yes  No

I feel safe in my home  always  sometimes  never

I use tobacco  never  sometimes  regularly since age \_\_\_\_\_

I am interested in quitting tobacco  Yes  No  I do not use tobacco

I drink alcohol  never  sometimes  regularly since age \_\_\_\_\_

I am interested in quitting alcohol consumption  Yes  No  I do not consume alcohol

I consume caffeine  never  sometimes  regularly

I am interested in decreasing my caffeine consumption  Yes  No  I do not consume caffeine

I use recreational drugs  never  sometimes  regularly

I am interested in quitting recreational drug usage  Yes  No  I do not use recreational drugs

How would you describe your overall health?  Poor  Fair  Good  Excellent

How would you describe your exercise and activity?

I exercise 1 time per week  I exercise 2-3 times per week  I exercise 4 or more times per week

I do not exercise  I would like to exercise but I am not currently

I enjoy the following activities: (check all that apply)

- walking    running    aerobics    yoga    pilates    elliptical machine    treadmill
- free weights    swimming    group classes    organized sports

Any dietary restrictions?    No    Yes: \_\_\_\_\_

How many servings of calcium daily?    1-2 servings    3-4 servings    5 or more servings

Supplements:    No    Yes

If yes: (check all that apply)    Calcium    Multivitamin    Folic Acid    Other: \_\_\_\_\_

Have you had a recent weight loss or weight gain?    No    Yes, how many pounds: \_\_\_\_\_

Do you wish to loose weight?    No    Yes, how many pounds: \_\_\_\_\_

How many times do you eat daily?    one time    two times    three times    four or more times

Do you eat snacks throughout the day?    never    rarely    sometimes    often

Do you skip meals?    never    rarely    sometimes    often

Please check one statement: Overall I have    positive feelings about self    negative feelings about self

My strengths are: \_\_\_\_\_

My weaknesses are: \_\_\_\_\_

Do you practice any form of Religion?    No    Yes, denomination: \_\_\_\_\_

Highest level of education obtained:    Grade school    Jr. High    High School    Associate's degree  
 Bachelor's degree    Master's degree    Doctorate

On average, how many hours of sleep do you get a night?    less than 6 hours    7-9 hours    10-12 hours

Do you routinely take medication to help you sleep at night?    No    Yes, type: \_\_\_\_\_

Date of last physical: \_\_\_\_\_      Date of last Pap smear: \_\_\_\_\_

Date of last mammogram: \_\_\_\_\_      Date of last tetanus injection: \_\_\_\_\_

Do you receive an annual Flu vaccine?    Yes    No

Have you been immunized against Hepatitis A?    Yes    No      Hepatitis B?    Yes    No

Date of last eye exam: \_\_\_\_\_      Date of last dental exam: \_\_\_\_\_

Corrective eyewear:    No    Yes, I use: (check all that apply)    Eyeglasses    Contacts

Do you have any difficulty hearing?    Yes    No      Do you wear a hearing aide?    Yes    No

Current medications: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are your parents still living?

Mother    Yes    No, deceased age \_\_\_\_\_

Father    Yes    No, deceased age \_\_\_\_\_

Do you have ay siblings?

No    Yes

Are there any health conditions that may run in your family that concerns you?

No    Yes, please explain: \_\_\_\_\_

**Insurance Coverage**

Primary Insurance Company: \_\_\_\_\_

Mailing Address for Medical Claims: \_\_\_\_\_

Policy/Member number: \_\_\_\_\_ Group number: \_\_\_\_\_

Cardholder's name: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_

Mailing Address for Medical Claims: \_\_\_\_\_

Policy/Member number: \_\_\_\_\_ Group number: \_\_\_\_\_

Cardholder's name: \_\_\_\_\_

**Emergency Contact**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone number(s): \_\_\_\_\_

**Health Care Providers**

Primary Care Provider: \_\_\_\_\_

OB/GYN: \_\_\_\_\_

Mental Health Provider: \_\_\_\_\_

Specialist(s): \_\_\_\_\_

**Allergies (check all that apply)**

I have no known allergies       I am allergic to latex

I am allergic to medication, please list: \_\_\_\_\_

When I take this medication I:     develop a rash     have difficulty breathing     other: \_\_\_\_\_

I have other allergies, please explain: \_\_\_\_\_

**Past Medical History**

Condition	Yes	No	Comments
Arthritis			
Autoimmune disorder			
Diabetes			
Hypertension			
Heart Disease			
Cancer			
Kidney Disease/UTIs			
Incontinence			
Skin Disorders (rash, lesions, moles)			
Neurological/Epilepsy			
Mental Health/Psychiatry			
Hepatitis/Liver Disease			
Varicosities/Phlebitis			
Thyroid Dysfunction			
Lungs (TB, Asthma, Bronchitis)			
Breast Abnormalities			
GYN Problems			
History of abnormal Pap test			Date:
History abnormal cholesterol			Date:
History of abuse (emotional, physical, sexual)			Counseling/Treatment:
Trauma/Injuries (car accidents, etc)			
Have you ever had a blood transfusion?			Date:
History of STI (sexually transmitted infection)			

**Surgical History**

Year	Procedure

**Vitals**

**Weight:** \_\_\_\_\_ **B/P:** \_\_\_\_\_ **Pulse:** \_\_\_\_\_ **Respirations:** \_\_\_\_\_

**Self reported Height:** \_\_\_\_\_ **BMI:** \_\_\_\_\_

**Obstetrical/Gynecological History**

Monthly Menses:  No  Yes, LMP: \_\_\_\_\_ **lasting** \_\_\_\_\_ **days**

occurring more than once a month  occurring less than once a month

Hysterectomy  Menopausal

Have you ever been pregnant?  No  Yes

-If yes, total number of pregnancies: \_\_\_\_\_

-Full term \_\_\_ premature \_\_\_ SAB \_\_\_ EAB \_\_\_

vaginal delivery  C-section

Complications: \_\_\_\_\_

Monthly self breast exams?  No  Yes

Sexually active?  No  Yes

-If yes, practice safe sex habits?  No  Yes

-If yes, contraceptive use?  No  Yes, Type: \_\_\_\_\_

-If yes, multi-vitamin or folic acid supplementations?  No  Yes

-Any concerns or questions?  No  Yes, \_\_\_\_\_

\_\_\_\_\_

Hormone Replacement Therapy:  No  Yes, Type: \_\_\_\_\_

-If yes, since when: \_\_\_\_\_

**What areas of your health are you most concerned about?**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Healthy Living Goals:**

1. \_\_\_\_\_

\_\_\_\_\_

2. \_\_\_\_\_

\_\_\_\_\_

3. \_\_\_\_\_

\_\_\_\_\_

4. \_\_\_\_\_

\_\_\_\_\_