Well-Woman Follow-up **Brandee Yarbrough, APRN, FNP-BC**

Name: _____

Date of Birth: _____ Age: _____

Do you smoke? Yes or No If so, how many packs per day? _____

Pregnancies: ____ Abortions: ____ Living children: ____ Full term births: ____ Premature births: ____

Any family history of:

Breast cancer: Yes or No IF Yes, Relation: _____

Colon cancer: Yes or No

Uterine cancer: Yes or No

Ovarian cancer: Yes or No

Osteoporosis: Yes or No

Heart Disease: Yes or No

Do you have any allergies? Yes or No If so, list: _____

When was your last mammogram? _____

When was your last PAP? ____ 1 year ____ 2 years ____ > 3 years

Were the results normal? Yes or No Have you ever had an abnormal PAP result? Yes or No

When was your last period? _____ Have you had a hysterectomy? Yes or No Year: _____

Are your periods regular? Yes or No

How often do you have a cycle? _____ How many days does your period last? _____

The blood flow is: _____ Light _____ Moderate _____ Heavy

Do you have bleeding in between periods? Yes or No

Do you have any vaginal discharge? Yes or No

Are you sexually active? Yes or No

If yes, Do you use birth control? Yes or No Method: _____

Have you ever had a sexually transmitted illness? Yes or No

Have you ever used fertility medicines? Yes or No

Do you have hot flashes? Yes or No

Are you on hormone replacement? Yes or No

Do you have a history of breast problems? Yes or No

How much of a problem, if any, is bladder control for you? ___ Not a problem ___ Small problem ___ Big problem

Do you feel safe in your environment? Yes or No

How would you describe your emotional health? ____ Calm or peaceful ____ Energetic ____ Downhearted or blue

How often does your physical health interfere with your daily activities? ___ Almost Never ___ Occasionally ___ Frequently

Please list any concerns*: _____

(*Maximum of 3 problems can be discussed per clinic visit)