

Women's Health by Design

First Name: _____ Middle / Nick Name: _____ Last Name: _____ Suffix: _____ DOB: _____

Street: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Emergency Contact: _____ Relation: _____ Phone: _____

Referring Medical Provider: _____ Medical Group: _____ Phone: _____ Fax: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Other Medical Provider: _____ Medical Group: _____ Phone: _____ Fax: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Medications: _____

Allergies: _____

Do you take all of your medications only in the dose(s) and manner prescribed? Yes No Sometimes

Do you avoid all use of "recreational" and street drugs? Yes No

How ready are you to make changes in your lifestyle to improve your health and safety?

Haven't thought about it

Thinking about making

Planning to change

Very ready

Have already started making changes

Not interested in making changes

Risk Factors

Have you or anyone in your family had any of the following health problems (Check all that apply)

Family	Self
_____ Heart Disease (heart attack, surgery, stents, chest pain)	_____
_____ Diabetes	_____
_____ High Blood Pressure	_____
_____ Stroke	_____
_____ Breast Cancer	_____
_____ Cervical Cancer	_____
_____ Colon Cancer	_____
_____ Lung Cancer	_____
_____ Polycystic Ovarian Syndrome	_____
_____ Ovarian Cancer	_____
_____ Uterine Cancer	_____
_____ Skin Cancer	_____
_____ Osteoporosis	_____
_____ Asthma	_____
_____ Lung Problems-Chronic Lung Disease	_____
_____ Chronic Back Pain	_____

Tobacco

Did you smoke?	Yes	No
Do you smoke?	Yes	No
How often do you smoke?	Daily or Social	
How much do you smoke?	Packs/Day	
Do you use smokeless tobacco?	Yes	No
How often do you use smokeless tobacco?	Times/Day	
If you use tobacco, are you interested in quitting?	Yes	No

Exercise/Diet

How often do you exercise (walking, running, cycling, swimming, weight lifting)?	None	3 times per week	5-7 times per week	Daily
How often do you stretch or do any flexibility exercises?	None	1-2 times per week	3-4 times per week	Daily
Do you eat 5 fruits and vegetables daily?	Yes	No		
How often do you eat red meat?	Never	One time weekly	3 times weekly	>5 times weekly
How often do you eat fried foods?	Never	One time weekly	3 times weekly	>5 times weekly
How often do you eat whole grain breads and cereals, such as whole wheat bread, oatmeal, shredded wheat, whole wheat pasta, etc?	Never	Sometimes	Most of the time	Always
How often do you eat fish?	Never	One time per week	3 times per week	>5 times per week
How often do you drink alcohol?	Never	One time per week	3 times per week	>5 times per week
Do you eat low-fat or non-fat dairy products?	Yes	No		

Orthopedic

Does joint pain keep you from exercise?	Yes	No
Does joint pain keep you from taking care of yourself, your family, or your home?	Yes	No
Have you had back or neck pain that has persisted for more than 4 weeks?	Yes	No
Have you had severe back or neck pain long- or short-term that:		
A. Is accompanied by a loss of bowel and bladder control?	Yes	No
B. Is accompanied by pain or numbness in one or both?	Yes	No
C. Is not relieved with over-the-counter pain medications?	Yes	No
D. Wakes you up at night?	Yes	No
Do you experience redness, warmth, or swelling in your joints?	Yes	No
Do you suffer from fatigue?	Yes	No

Prevention

Do you see your personal medical provider every year or as requested by your provider?	Yes	No
If over the age of 40 years, have you had your bone density measured if you are at risk of osteoporosis?	Yes	No
If over the age of 40 years, have you had an eye exam?	Yes	No
If over the age of 40 years, have you had a baseline EKG to screen for heart problems?	Yes	No
If over the age of 50 years, have you had a colorectal screening?	Yes	No
Do you receive a flu vaccine yearly, especially if you are over 60 years of age?	Yes	No
Do you receive a pneumonia vaccine, especially if you are over 60 years of age?	Yes	No
Do you get an updated tetanus shot every 10 years?	Yes	No
Have you had an updated hepatitis B vaccination?	Yes	No
Have you had a dental exam in the last year?	Yes	No
Have you had your hearing checked in the last 3 years?	Yes	No
Do you give yourself a self-breast exam every month?	Yes	No
In your forties, do you have a mammogram every 1-2 years?	Yes	No
In your fifties and older, do you have a mammogram every year?	Yes	No
Do you get a pap smear yearly or more often as recommended by your health care provider?	Yes	No
Do you get a pap smear every 1-3 years after menopause?	Yes	No
Do you practice safe sex?	Yes	No

Safety

Do you use sunscreen to protect your skin when in the sun?	Yes	No	Occasionally
Do you wear UV (ultra-violet) protective sunglasses when outdoors?	Yes	No	Occasionally
How often do you wear seatbelts when riding in a car?	Always	Sometimes	Never
Do you ride a Bike? How often do you wear a helmet when riding a bike?	Always	Sometimes	Never

Stress/Fatigue

Do you feel tired much of the time?	Yes	No
How many hours of sleep do you get each night?	_____Hours	
Do you snore?	Yes	No
Have you been told you stop breathing during sleep?	Yes	No

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently try to work out how they would have affected you. Use the scale to choose the most appropriate number for each situation:

Sitting and Reading

No chance of dozing Slight chance of dozing Moderate chance of dozing High chance of dozing

Watching TV

No chance of dozing Slight chance of dozing Moderate chance of dozing High chance of dozing

Sitting inactive in a public place (e.g. a theater or a meeting)

No chance of dozing Slight chance of dozing Moderate chance of dozing High chance of dozing

As a passenger in a car for an hour without a break

No chance of dozing Slight chance of dozing Moderate chance of dozing High chance of dozing

Lying down to rest in the afternoon when circumstances permit

No chance of dozing Slight chance of dozing Moderate chance of dozing High chance of dozing

Sitting and talking to someone

No chance of dozing Slight chance of dozing Moderate chance of dozing High chance of dozing

Sitting quietly after a lunch without alcohol

No chance of dozing Slight chance of dozing Moderate chance of dozing High chance of dozing

In a car, while stopped for a few minutes in traffic

No chance of dozing Slight chance of dozing Moderate chance of dozing High chance of dozing

Do you take time to do activities just for fun or relaxation? If so, how often?	Yes	No			
	Once/week	2 times/week	3 times/week	Daily	
Do you have frequent headaches?	Yes	No			
Over the last 6 weeks, how would you rate your overall happiness?	Very Happy	Happy	Unhappy	Very Unhappy	
During the past 3 months, how often are you frustrated or upset about something?	Daily	>3 times/week	Weekly	Monthly	
How would you rate your current stress level?	Lighter than normal	Normal	Heavy	Excessive	
How well do you feel you cope with your stress?	Not well at all	Some times very well	Most of the time very well		
Who do you consider a part of your support system?	Family	Friends	Co-workers	Boss	Multiple Support
Do you feel safe in your home?	Yes	No			
Is there anything else you would like to discuss confidentially with the nurse or other health care provider?				Yes	No