



Well Woman Exam

Name: _____

Gyn History

Date of last menstrual period: _____

Sexually Active: yes no

If yes, age of first sexual activity: _____

Date of last pap smear: _____

History of abnormal pap smear: yes no

History of STD: yes no

Birth Control: yes no

- Type? _____

OB History

Total # of Pregnancies: _____

History of c-section: yes no

History of miscarriage: yes no

Preventive History

Gardasil Vaccine (11-26 years old): yes no

Date of last mammogram: _____

Date of last Dexa Scan: _____

Date of last colonoscopy: _____

Date of last Tetanus booster: _____

Daily multivitamin: yes no

Calcium Supplement: yes no

Tobacco Use: yes no

Please list any current concerns: