DR. LADYBUG'S FAMILY PRACTICE

Karla Davidson-Cox, M.D.

Well Woman Exam Questionnaire

Patient Name: _____

Date: _____ DOB: _____

When was your last menstrual period? _____

When was your last pap smear? _____

When was your last mammogram? _____

Have you ever had an abnormal pap smear? ☐ *Yes* ☐ *No*

Have you ever had an abnormal mammogram? ☐ *Yes* ☐ *No*

Have you had a hysterectomy? ☐ *Yes* ☐ *No*

Do you have a family history or personal history of any of the following:

☐ *Breast Cancer* ☐ *Uterine Cancer* ☐ *Ovarian Cancer* ☐ *None*

Do you have abnormal vaginal bleeding (i.e. after menopause, after intercourse)?

☐ *Yes* ☐ *No*

How many times have you been pregnant? _____

How many living children have you had? _____

How many incomplete pregnancies have you had? _____

Do you smoke or have you smoked in the past? ☐ *Yes* ☐ *No*

Have you ever had a sexually transmitted disease (HPV, trichomonas, gonorrhea, chlamydia)? ☐ *Yes* ☐ *No*