

**Woman2Woman**

**Obstetrics & Gynecology**

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**Wellness Exam Questionnaire**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date that your last period began: \_\_\_\_\_\_\_\_\_\_\_\_ Do you have heavy periods? \_\_\_\_\_\_\_\_\_\_  
Are your periods regular? \_\_\_\_\_\_\_\_\_\_ Do you have painful periods? \_\_\_\_\_\_\_\_\_\_**

**When was your last mammogram? \_\_\_\_\_\_\_\_\_\_\_ colonoscopy? \_\_\_\_\_\_\_\_\_\_\_ bone density? \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Any history of an abnormal pap smear? \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Current birth control: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
 Are happy with your current birth control? \_\_\_\_\_\_\_\_\_\_**

**Have you had a tubal ligation? \_\_\_\_\_\_\_\_\_\_\_ Are you interested in a tubal ligation? \_\_\_\_\_\_\_\_\_\_**

**Do you have any loss of urine when coughing? (Yes or No) \_\_\_\_\_\_\_\_\_\_ Dropped Bladder? \_\_\_\_\_\_\_\_\_\_\_\_**

**Any difficulty keeping tampons in place? \_\_\_\_\_\_\_\_\_\_ Enlarged vaginal opening or labia? \_\_\_\_\_\_\_\_\_\_\_\_**

**Painful sex or pain w/ insertion? \_\_\_\_\_\_\_\_\_\_\_\_\_ Difficulty achieving orgasm? \_\_\_\_\_\_\_\_\_\_\_\_**

**Current Medications: Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**1.**

**2.**

**3.**

**4.**

**Do you need any prescription refills? (Yes or No) \_\_\_\_\_\_\_\_\_\_**

**What pharmacy & location do you use? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Describe any other problems or concerns that you would like to discuss today:**

**Would you like STI testing with your pap today? ( Yes or No)**

**Would you like the HPV vaccine? ( Yes or No )**