Women's Health Questionnaire

Chart/ID No. _____

Name: _____ Date: _____

This form asks about your health. Your answers to these questions will help our staff to meet your needs. You do not have to answer any question that makes you feel uncomfortable. Information is strictly confidential. Please circle either yes or no for each question.

Health History:

1.	Do you see a doctor at least once a year for a physical exam?	Yes	No
2.	Do you have trouble getting to a doctor?	Yes	No
3.	Do you have problems keeping your health care appointment?	Yes	No
4.	Do you have a physical disability?	Yes	No
5.	Are you currently using any type of birth control/family planning?	Yes	No
6.	Have you ever lost a baby?	Yes	No
7.	Have you ever had a low birth weight baby?	Yes	No
8.	Do you understand "baby spacing"?	Yes	No
9.	Have you had a pap smear in the last 2 years?	Yes	No
10.	Have you ever had an abnormal pap smear?	Yes	No
11.	Have you had a sexually transmitted disease in the past 2 years?	Yes	No
12.	Have you been tested for HIV in the past year?	Yes	No
13.	Have you ever had a shot for Rubella?	Yes	No
14.	Do you douche?	Yes	No
15.	Do you know how to examine your breast?	Yes	No
16.	Have you ever had a breast lump?	Yes	No
	If yes, did they take cut and take a sample of the breast?	Yes	No

Nutrition and Physical Activity:

16. How many servings of fruit and vegetables do you eat a day? _____
17. How many caffeine drinks (coffee, soda, tea) do you drink a day? _____
18. What is your current weight? _____
19. What is your current height? _____
20. Body Mass Index (to be completed by staff) _____
21. Do you exercise 20 – 30 minutes/day three times a week Yes No
22. What type of exercise do you do? _____Walk _____Run _____Bike _____Other

Chronic Health:

23. Do you have or had any of the following medical problems/concerns?	CURRENT	PAST
High Blood Pressure	Yes	No
Diabetes	Yes	No
Heart Problems	Yes	No
Seizures	Yes	No
Vaginal Infection (itching/discharge)	Yes	No
Anemia	Yes	No
Cancer (specify: _____)	Yes	No
Eating Disorder (specify: _____)	Yes	No
Allergies (specify: _____)	Yes	No
Other: _____	Yes	No
24. Have you seen a dentist in the last year?	Yes	No

Stress and Mental Health:

25. Have you received help for any mental or emotional health problems? Yes No
26. Do you take any medication or receive counseling? Yes No
27. Have you ever been treated for depression? Yes No
28. Have you ever been treated for anxiety? Yes No
29. Have you ever thought about killing yourself? Yes No

Within the past two weeks, how often have you? (Staff: See Resource for assessment scale directions)	Not at All (0)	From time to time (1)	Quite Often (2)	Most of the time (3)	Staff Use
Been "down in the dumps"?					
Had crying spells?					
Had thoughts of hurting yourself or someone else?					
Had problems sleeping?					
Been feeling hopeless about the future?					
Had problems concentrating or making decisions?					
Felt frustrated?					
Felt anxious or nervous?					
Blamed yourself for things?					
Had negative thoughts about yourself?					
TOTAL					

30. Circle all the things that have happened to you in the past year?

married lost my job divorced money problems
moved legal problems changed job family concerns

31. How do you rate your stress right now?

_____ Not very stressed _____ A little stressed _____ Very stressed

Abuse History:

32. Has anyone ever tried to hurt or hit you? Yes No
33. Are you afraid of someone hurting or hitting you now? Yes No

Social Support:

34. Is there someone in your family you could talk to if you had a problem? Yes No
35. Do you have someone outside your family to talk to if you had a problem? Yes No
36. Do you have a problem you need to talk to someone about? Yes No

Substance Abuse:

37. Do you consider one of your parents to be an addict or alcoholic? Yes No
38. Has your partner's drinking or drug use been a problem for you? Yes No
39. Have you had a problem with drugs or alcohol in the past? Yes No
40. Have you ever-used drugs or alcohol during this pregnancy? Yes No N/A
41. Have you ever used or currently using the following:
    - Cigarettes/Cigar/Pipe Yes No
    - Mixed drink/Cocktail/ Wine Cooler/Beer/Wine Yes No
    - Marijuana (pot, hash, grass) Yes No
    - Cocaine/Crack Yes No
    - Other drugs (specify: _____) Yes No
42. Have you ever been treated for an alcohol problem? Yes No
43. Have you ever been treated for a drug problem? Yes No
44. Have you attended a smoking cessation class? Yes No

Reviewed by: _____ Date: _____

Additional Comments: _____

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