# Washington Adult Congenital Heart
# Follow-up Patient Visit Questionnaire for Women

Version: 9/15/17

**Part A: Patient Information**

Name: _____

Date of Birth (MM/DD/YYYY): ___ ___/___ ___/___ ___ Phone Number: _____

Date of Visit (MM/DD/YYYY): ___ ___/___ ___/___ ___ Email Address: _____

**Part B: Health Questionnaire**

Please let us know in what way we can best assist you:

_____

**Medical History:** Please list all current and prior illnesses, injuries, operations, and hospital stays you can remember. Feel free to continue on the back of this page.

_____

_____

**Do you have a Primary Care Provider/General Practitioner?**

**No ☐ If No, why not?**_____

**Yes ☐ If Yes, Date of last Primary Care visit**_____ **Primary Care Provider name:**_____

Approximate weight 5 years ago:_____ Current weight:_____

How much time (at work or school) have you lost in the last 6 months from illness or injury? _____

**Personal History:**

With whom do you share your home? Spouse Children Partner Pets Other None

**Do you**:

- **Smoke?** □ Y □ N If yes, how much _____How Long _____
  - Did you ever smoke? □ Y □ N How much _____ When stopped_____
- **Drink alcohol?** □ Y □ N
  - If yes, please describe average amount /wk _____
  - Has anyone ever told you that you should cut down? □ Y □ N
- **Drink energy drinks** (i.e., Redbull, Monster, 5-hour Energy etc)? □ Y □ N
  - If yes, please describe average amount /wk _____
- **Use Marijuana / other substances?** □ Y □ N
  - If yes, please describe type & average amount /wk _____

**Exercise, Relaxation & Wellbeing:**

Do you have any form of regular or occasional exercise program? □ Yes □ No

If yes, what kind of exercise do you do?_____

How often do you exercise? _____

For how long do you exercise?_____

What do you do to relax? _____

Do you practice meditation or yoga for stress relief? If not, would you like more information?

□ Yes □ No □ Yes □ No

| **Over the past two weeks, have you been bothered by these problems?** | **Not at all** | **Several days** | **More days than not** | **Nearly every day** |
|---|---|---|---|---|
| Feeling nervous, anxious, or on edge | | | | |
| Not being able to stop or control worrying | | | | |
| Feeling down, depressed or hopeless | | | | |
| Little interest or pleasure in doing things | | | | |

**Over the last week, how much have you been bothered by:**

| | Not at all | | | a little | | | moderately | | | severely |
|---|---|---|---|---|---|---|---|---|---|---|
| Feeling stressed | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| Feeling angry | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| Not having the social support you feel you need | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |

The thought of harming myself has occurred to me. □ Y □ N

Have you ever been a victim of abuse? □ Y □ N

Have you ever been advised to be or been under psychiatric care or other counseling? □ Y □ N

**Average number of hours you sleep each night _____**

□ Recent Change in sleep pattern
□ Trouble falling into sleep
□ Trouble waking early, unable to fall back asleep
□ Feel rested when awake each morning
□ Tired much of the time

**Please let us know more about your plans for your future health care:**

□ I have a Living Will
□ I have set up a Durable Power of Attorney for Health Care
□ I have discussed my wishes for ultimate [end-of-life] health care with my family

**If you do not have plans for your future health care, please tell us why?**

□ I don't know what this is
□ I don't have time to set these things up
□ I don't know where to start
□ Other_____

**Education - please circle highest completed :**

1. Grades 1 -8
2. Some High School
3. High School
4. Some College
5. Associates Degree
6. Bachelors Degree
7. Masters Degree
8. Other advanced Degree

**Race – please circle**

1. White
2. Black
3. Asian
4. Hispanic/Latino
5. American Indian
6. Hawaiian
7. Other
8. Decline to answer

**Follow-up Visit in _____ Months**

**Please check off any of the following issues *<u>you have had or currently have since your last visit</u>*:**

**Gynecological:** **No Changes** □
Frequency of Periods:
____-day cycle, ___ days of flow
Periods are: Light Moderate Heavy
Timing is: Regular Irregular
□ Recent change in periods?
□ Last Menstrual Period _____
□ Premenstrual symptoms _____
□ Do you use Birth Control?
Type_____
□ Painful intercourse

□ Pregnancies:
Number _____
Deliveries ____
Complicated Pregnancies _____
□ Hot flashes /other menopausal symptoms
When started _____
□ Have periods stopped completely?
If so, at what age _____
□ Fibroids, endometriosis, ovarian cysts
□ Pelvic Inflammatory Disease
□ Abnormal vaginal discharge
Gynecologist name:_____
Date of Last Pap Smear _____ Normal? Y N
□ History of Abnormal Pap Smear?
Abnormal in what way _____
Treatment _____
Follow-up _____

**Breasts:** **No Changes** □
□ Perform regular breast self-exams?
Any abnormalities _____
□ When was your last mammogram?_____
Any abnormalities? _____
□ History of breast biopsies?
Findings _____

**Head:** **No Changes** □
□ Eye disease or injury
□ Double vision
□ Wear glasses or contacts
Correction required to drive?____
□ Eye Surgery/Correction
□ Glaucoma
Last tested for Glaucoma _____
□ Hearing troubles, Ringing in Ears, Ear Disease
□ Troubles with Vertigo (Room seems to spin)
□ Nose Bleeds
□ Trouble breathing through your nose
□ Sinus troubles or infections
□ Severe Dizziness
□ Seizures or Convulsions

**Neck:** **No Changes** □
□ Thyroid Ailment
□ Neck Arthritis, Neck Surgery or Neck Chiropractic Problem
□ Swelling of the neck or Lymph Nodes

**Respiratory:** **No Changes** □
□ Chronic cough (including "smokers cough")
□ Do you cough up phlegm? Y N
If Yes, what color is it? _____
□ Spitting or coughing of blood
□ Shortness of breath
□ Asthma or wheezing
□ Night sweats
□ Skin tests for Tuberculosis
Last done _____ Positive? Y N
□ Year of Last Chest X Ray _____
Was it Normal? Y N

**Cardiovascular:** **No Changes** □
□ Angina, chest pain or pressure
□ Shortness of breath when lying down
□ Ankles or legs swelling
□ Rapid, hard or skipped Heart Beat
□ Are you supposed to take antibiotics before dental work?

**Dental:** **No Changes** □
□ Wear dentures
□ Gum disease /gingivitis
□ Floss regularly
□ Regular teeth cleaning
Last visit _____
□ Dental extractions

**Gastrointestinal:** **No Changes** □

□ Ulcer history
□ Heartburn or indigestion
□ Often use antacids
□ Trouble swallowing / foods sticking in throat
□ Intolerance to foods
□ Gallbladder trouble
□ Do you often vomit?
□ Ever vomit blood?
□ Crampy abdominal pains
□ Any liver trouble
□ Chronic constipation
□ Frequent diarrhea
□ Recent change in bowel habits
□ Hemorrhoids or Piles
Require/required surgery? Y/N
□ Use Laxatives
Bowel Movement Frequency per Week _____

**Genitourinary:** **No Changes** □

□ Loss of urine when cough or sneeze
□ Kidney or bladder infections
□ Feeling that you must go constantly
□ Blood in urine
□ Kidney stones
□ Difficulty in starting urination
□ Get up at night to urinate?
How Often _____
□ Are you experiencing any of the following symptoms of sexual dysfunction?
Low sexual desire/interest in sex_____
Difficulties with sexual arousal_____
Pain with intercourse_____

**Musculoskeletal:** **No Changes** □

□ Arthritis
Type if known _____
□ Weakness which is new or limits what do you
□ Unexplained muscle pains
□ Difficulty in walking
□ Pain in calves or buttocks on walking
Relieved at rest? Y N

**Skin:** **No Changes** □

□ Frequent Skin Infections
□ Skin Diseases
What kind? _____
□ History of increased sun exposure, or frequent prior sunburns
□ Wear sun screen and protective clothing when sun exposed
□ Date of Last Dermatology Visit_____
Doctor:_____ _____
□ History of removal of skin lesions
Type: _____

**Blood Disorders:** **No Changes** □

□ History of anemia
When _____
□ Excessive bleeding or bruising
When _____
□ Date of last blood test _____
Any abnormalities? Y N