NAME: DATE:

WELL-WOMAN EXAM

To help your doctor during today's health exam, please complete items 1 through 11.

1. Age: _____
   First day of last menstrual period (or first year of menstruation, if through menopause): _____

2. Number of times pregnant: _____
   Number of completed pregnancies: _____
   Date of last pregnancy: _____
   If you are under age 55, what method of birth control do you use? _____
   If pills, what kind?_____
   How many years have you used the pills? _____
   Are you planning a pregnancy in the next 6-12 months? ☐ YES ☐ NO

3. If you are through menopause or over age 50, do you take any of the following pills?
   Calcium ☐ YES ☐ NO
   Estrogen (Premarin) ☐ YES ☐ NO
   Progesterone (Provera) ☐ YES ☐ NO

4. Have you had any of the following problems:
   a. Abnormal Pap smears ☐ YES ☐ NO
      If yes, date: _____ problem: _____
      For abnormality, did you have any of the following done:
      Colposcopy ☐ YES ☐ NO
      Biopsies ☐ YES ☐ NO
      Surgery ☐ YES ☐ NO
   b. High blood pressure, heart disease or high cholesterol ☐ YES ☐ NO
   c. Migraine headaches, blood clot in legs or cancer ☐ YES ☐ NO
   d. Abdominal or pelvic surgery or special tests ☐ YES ☐ NO
      If yes, what: _____ when: _____

5. Do you have any of the following:
   a. Problems with present method of birth control ☐ YES ☐ NO
   b. Bleeding between periods or since periods stopped ☐ YES ☐ NO
   c. Pain with intercourse or periods ☐ YES ☐ NO
   d. Any problem with interest in or enjoying intercourse ☐ YES ☐ NO
   e. A new or enlarging lump in breast ☐ YES ☐ NO
   f. Change in size/firmness of stools ☐ YES ☐ NO
   g. Change in size/color of a mole ☐ YES ☐ NO
   h. Severe headaches ☐ YES ☐ NO
   i. Pain in the leg, chest, abdomen or joints ☐ YES ☐ NO
   j. Trouble falling or staying asleep ☐ YES ☐ NO
   k. Often feeling down, depressed or hopeless during the past month ☐ YES ☐ NO
   l. Often having little interest or pleasure in doing things during the past month ☐ YES ☐ NO
   m. Conflict in your family or relationships, sometimes handled by pushing, hitting or cruelty ☐ YES ☐ NO

6. Do you have a parent, brother or sister with a history of the following:
   a. Cancer of the breast, intestine or female organs ☐ YES ☐ NO
   b. Heart pain or heart attacks before the age of 55 ☐ YES ☐ NO
   If yes to a or b:
   Relation: _____ Type: _____
   Relation: _____ Type: _____

7. Osteoporosis (thin-bone) screening:
   a. Is there a history of any relatives with the following: stooping over or losing height as they got older, "thin bones," hip fractures ☐ YES ☐ NO
      If yes, relation: _____
   b. Have you had any of the following:
      Height loss ☐ YES ☐ NO
      Broken hip or wrist ☐ YES ☐ NO
      Bone-density test ☐ YES ☐ NO
   c. Do you take any of the following:
      Steroids (prednisone) ☐ YES ☐ NO
      Medication for thyroid, seizures or thin bones ☐ YES ☐ NO

8. Have you ever used tobacco? ☐ YES ☐ NO
   If yes:
   Average number of packs/day: _____
   Number of years smoked: _____
   Year quit:
   When are you planning to quit?
   ☐ now ☐ next 6 months ☐ sometime ☐ never

continued ➤

NAME:

9. Do you drink alcohol? ☐ YES ☐ NO

If yes:

a. Have you ever felt you should cut down on your drinking? ☐ YES ☐ NO

b. Have people ever annoyed you by nagging you about your drinking? ☐ YES ☐ NO

c. Have you ever felt guilty about your drinking? ☐ YES ☐ NO

d. Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover? ☐ YES ☐ NO

10. Prevention:

a. Which of the following are included in your diet:

Grains and starches	☐ a lot	☐ some	☐ few
Vegetables	☐ a lot	☐ some	☐ few
Dairy foods	☐ a lot	☐ some	☐ few
Meats	☐ a lot	☐ some	☐ few
Sweets	☐ a lot	☐ some	☐ few

b. Exercise:

Activity _____

Days per week _____

Time/duration _____ minutes

Exertion: ☐ stroll ☐ mild ☐ heavy

c. Do you always wear seat belts? ☐ YES ☐ NO

d. If over 30 years old, have you had your cholesterol level checked in the past five years? ☐ N/A ☐ YES ☐ NO

e. Have you had a tetanus shot in the past 10 years? ☐ YES ☐ NO

f. Does your house have a working smoke detector? ☐ YES ☐ NO

g. Do you have firearms at home? ☐ YES ☐ NO

h. Have you had the shingles vaccination? ° Yes °No

h. Have you ever had a mammogram? ☐ YES ☐ NO

If yes, date of last: _____ where: _____

Have you ever had any abnormal mammograms? ☐ N/A ☐ YES ☐ NO

If yes, date: _____ problem: _____

For abnormality, did you have any of the following:

Biopsy ☐ YES ☐ NO

Cyst fluid drained ☐ YES ☐ NO

Surgery ☐ YES ☐ NO

i. How many sexual partners have you had in the last 12 months? ____ In your lifetime? ____

j. When is the last time you had a dental check-up?_____

11. Please describe any concerns you have:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Thank you for your help.

Your Doctor has the next page

continued ➤

NAME:

WELL-WOMAN EXAM

Date: _____

Height	Weight	Overweight	BP
		☐ YES ☐ NO	

If necessary				ALLERGIES
Temp	Pulse	Resp	O_2 Sat	

Other complaints/hpi: _____

_____

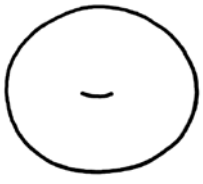
Physical exam:

Oral exam (if smoker): Normal Abnormal: _____

Vaginal: Normal Abnormal: _____

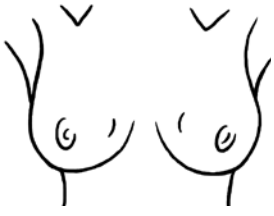
Ext. genitalia: Normal Abnormal:

Cervix: Normal Abnormal:



Uterus and adnexa: Normal Abnormal:

Breasts: Normal (no masses; no skin, nipple or axillary changes) Abnormal:



As indicated by past medical history (none of the following are specifically recommended by USPSTF):

HEENT: Normal Abnormal: _____

Heart: Normal Abnormal: _____

Lungs: Normal Abnormal: _____

Rectum: Normal Abnormal: _____

Abdomen: Normal Abnormal: _____

Skin: Normal Abnormal: _____

Extremities: Normal Abnormal: _____

Diagnoses (#s correspond to problem list): _____

_____

Plan:

All patients:

- ☐ Handout given and reinforced healthy diet, lifestyle, exercise and safety
- ☐ Pap smear
- ☐ Folic acid Rx
- ☐ Calcium Rx: ☐ 600mg/d ☐ 1200mg/d
- ☐ Immunizations: flu, Td (q 10 yrs)
- ☐ Recommended dental exam
- ☐ Other:

Over 40 y/o:

- ☐ Mammogram(controversial 40-50 y/o, consider q 2 yrs)

Over 50 y/o:

- ☐ Reminded to report postmenopausal bleeding
- ☐ Cholesterol
- ☐ Hormone replacement: ☐ estrogen 0.___ mg/d ☐ progesterone 2.5mg/d
- ☐ Colon cancer screen: ☐ colonoscopy ☐ ACBE ☐ flex sig ☐ stool guaiac x 3
- ☐ Bone density
- ☐ Coated ASA: ☐ 325 mg/d ☐ 81 mg/d
- ☐ Immunizations: pneumococcal (>65 y/o)

Follow-Up:

- ☐ Routine visit in _____ for _____
- ☐ Physical exam in _____

Name: _____

DOB: _____/_____/_____

Chart #: _____

Physician signature: _____

Physician name: _____

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