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 today? □ 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
      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
      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 ➤
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? □ 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 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:
    __________________________________________________________________________________
    __________________________________________________________________________________
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Thank you for your help.
WELL-WOMAN EXAM

Date: ____________________________

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<th>Height</th>
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<th>Overweight</th>
<th>BP</th>
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If necessary

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<th>Temp</th>
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ALLERGIES

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

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 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: _____________________________________________________