

# WELL-WOMAN EXAM

Patient's Name \_\_\_\_\_

## Patient section

Please answer the following questions. This will help your physician identify possible problems.

Your age: \_\_\_\_\_

When was your last mammogram? \_\_\_\_\_

When was your last period? \_\_\_\_\_

When was your last PAP test?  1 yr  2 yrs  >3yrs

Were the results normal?  Yes  No

Have you ever had an abnormal PAP test?  Yes  No

How often do you usually get your period? every \_\_\_ days

Are your periods usually regular?  Yes  No

How many days do your periods usually last? \_\_\_\_\_ days

The blood flow is:  Light  Moderate  Heavy

Do you have any bleeding between periods?  Yes  No

Do you have any vaginal discharge?  Yes  No

Are you sexually active?  Yes  No

If yes, do you and your partner use birth control?  Yes  No Method: \_\_\_\_\_

Have you ever had a sexually transmitted disease?

Yes  No

Has your mother ever been exposed to DES?  Yes  No

Have you ever used fertility medicines?  Yes  No

Do you have hot flashes?  Yes  No

Are you on hormone replacement?  Yes  No

Do you smoke?  Yes  No

How often do you perform self breast-exams?

Less often than monthly  Monthly

Do you have a history of breast problems?  Yes  No

Have you ever been abused?  Yes  No

Do you feel safe?  Yes  No

Is there any family history of:

Breast cancer?  Yes  No

Colon cancer?  Yes  No

Uterine cancer?  Yes  No

Ovarian cancer?  Yes  No

Other cancers?  Yes  No

Osteoporosis?  Yes  No

Heart disease?  Yes  No

Do you have any allergies?  Yes  No (list them below)

On a scale of 0 to 10, with 0 being no symptoms and 10 being severe symptoms, how would you describe the following (please circle):

Pain during your usual period:

0 1 2 3 4 5 6 7 8 9 10

Pain during sex:

0 1 2 3 4 5 6 7 8 9 10

PMS (premenstrual tension syndrome):

0 1 2 3 4 5 6 7 8 9 10

If you have been pregnant, please indicate how many:

Pregnancies \_\_\_ Abortions \_\_\_ Living children \_\_\_

Full-term live births \_\_\_ Premature births \_\_\_

Please list any other concerns: \_\_\_\_\_

## Physician section:

Abnormals should be described below or on the reverse side of this form. For VS and allergies, see separate note in chart.

NI Abn

HEENT

THYROID

LUNGS

HEART

NI Abn

ABDOMEN

SKIN

EXTREMITIES

NEURO

If there are any abnormalities, circle the specific one(s) and describe below or on reverse.

NI Abn

BREASTS

Masses Lumps Tenderness Symmetry

Nipple discharge Axilla

EXTERNAL GENITALIA

Appearance Hair distribution Lesions

URETHRA & MEATUS

Size Location Lesions Prolapse

Masses Tenderness Scarring

VAGINA

Appearance Estrogen effect for age/meds

Discharge Lesions Pelvic support

Cystocele Rectocele

CERVIX

Appearance Lesions Discharge

UTERUS

Size Contour Position Mobility

Tenderness Consistency Support

ADNEXA

Masses Tenderness Organomegaly Nodularity

BLADDER

Fullness Masses Tenderness

ANUS & PERINEUM

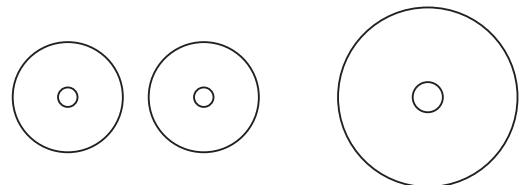
RECTAL

Tone Hemorrhoids Masses

HEMOCCULT

KOH/WET PREP

ACETIC ACID WASH



A:  Normal gyn/pap  Family planning  Pregnancy  HRT

P:  Pap  HRT info given  Caffeine ed  Stool OB

BSE info  Flex sig  Calcium ed

Mammogram \_\_\_\_\_  Dexa  Heel  Full

Return for pap 1 year or \_\_\_\_\_ RTC \_\_\_\_\_