**WELL-WOMAN EXAM**

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**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  YES  NO

 in the next 6-12 months?

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  YES  NO

 disease or high cholesterol

 c. Migraine headaches, blood clot  YES  NO

 in legs or cancer

 d. Abdominal or pelvic surgery  YES  NO

 or special tests

 If yes, what: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ when: \_\_\_\_\_\_\_\_\_

5. Do you have any of the following:

 a. Problems with present method  YES  NO

 of birth control

 b. Bleeding between periods or  YES  NO

 since periods stopped

 c. Pain with intercourse  YES  NO

 or periods

 d. Any problem with interest in or  YES  NO

 enjoying intercourse

 e. A new or enlarging lump  YES  NO

 in breast

 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  YES  NO

 or joints

 j. Trouble falling or staying asleep  YES  NO

 k. Often feeling down, depressed or  YES  NO

 hopeless during the past month

 l. Often having little interest or  YES  NO

 pleasure in doing things during

 the past month

 m. Conflict in your family or  YES  NO

 relationships, sometimes handled

 by pushing, hitting or cruelty

6. Do you have a parent, brother or sister with a history of

the following:

 a. Cancer of the breast, intestine  YES  NO

 or female organs

 b. Heart pain or heart attacks  YES  NO

 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  YES  NO

 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,  YES  NO

 seizures or thin bones

Form continues on next page >

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

9. Do you drink alcohol?  YES  NO

 If yes:

 a. Have you ever felt you should  YES  NO

 cut down on your drinking?

 b. Have people ever annoyed you  YES  NO

 by nagging you about your drinking?

 c. Have you ever felt guilty about  YES  NO

 your drinking?

 d. Have you ever had a drink first  YES  NO

 thing in the morning to steady your

 nerves or get rid of a hangover?

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 m N/A  YES  NO

 had your cholesterol level checked

 in the past five years?

 e. Have you had a tetanus shot  YES  NO

 in the past 10 years?

 f. Does your house have a working  YES  NO

 smoke detector?

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

 h. Have you ever had  YES  NO

 a mammogram?

 If yes, date of last: \_\_\_\_\_\_\_ where:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Have you ever had any  N/A  YES  NO

 abnormal mammograms?

 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.*

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**WELL-WOMAN EXAM**

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Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| Height | Weight | Overweight | BP |
|  |  |  yes  no |  |

**Other complaints/hpi:**

**Physical exam:**

 **Oral exam (if smoker):** Normal Abnormal:

 **Vaginal:** Normal Abnormal:

 **Ext. genitalia:** Normal Abnormal: (see drawing)

 **Cervix:** Normal Abnormal: (see drawing)

 **Uterus and adnexa:** Normal Abnormal: (see drawing)

 **Breasts:** Normal Abnormal: (see drawing)

 (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 40 y/o:**

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

**Follow-Up:**

 Routine visit in \_\_\_\_\_\_\_\_\_\_\_\_ for \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Physical exam in \_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_

|  |  |
| --- | --- |
| If necessary | ALLERGIES |
| Temp | Pulse | Resp | O2 Sat |
|  |  |  |  |

**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)

Physician signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Chart #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Developed by Peter A. Cardinal, MD, MHA, Gettysburg Hospital, Gettysburg, Pa. Copyright © 2003 American Academy of Family Physicians. Physicians may photocopy or adapt for use in their own practices; all other rights reserved. “Encounter Forms for Better Preventive Visits.” Cardinal PA. *Family Practice Management.* July/August 2003:35-40, www.aafp.org/fpm/20030700/35enco.html.