**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

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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)

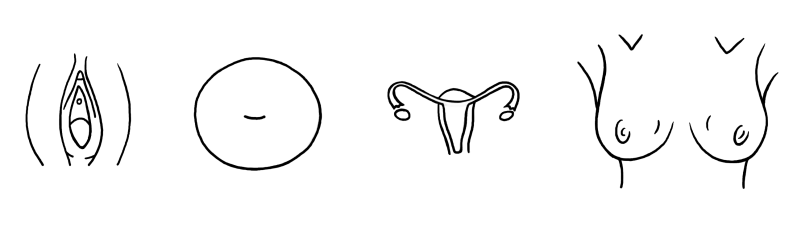
**Uterus and adnexa:** Normal Abnormal: (see drawing)

**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 #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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