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 ☐ ometime ☐ never

continued ➤

AAFP FPM

***FPM* Toolbox** To find more practice resources, visit https://www.aafp.org/fpm/toolbox.

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 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.

Name: _____ DOB: _____ Chart #: _____ Date: _____

Height	Weight	Overweight	BP
		☐ Yes ☐ No	

If necessary				Allergies
Temp	Pulse	Resp	O_2 Sat	

Other complaints/hpi: _____

_____

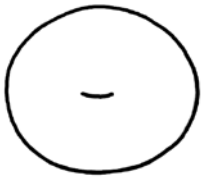
Physical exam:

Oral exam (if smoker): Normal Abnormal: _____

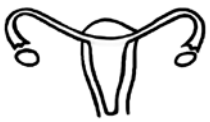
Vaginal: Normal Abnormal: _____

Ext. genitalia: Normal Abnormal

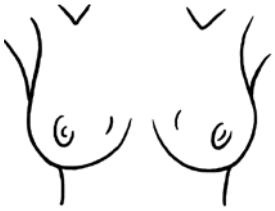
Cervix: Normal Abnormal



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 50 y/o:

- ☐ Reminded to report postmenopausal bleeding
- ☐ Mammogram (controversial, consider q 2 yrs)
- ☐ Colon cancer screen: ☐ colonoscopy ☐ ACBE ☐ flex sig ☐ stool guaiac x 3

Over 65 y/o:

- ☐ Bone density
- ☐ Immunizations: pneumococcal

Follow-Up:

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

Physician signature: _____ Physician name: _____