WELL-WOMAN EXAM ENCOUNTER FORM

Family Practice Management®

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
Diabetes? ☐ Yes ☐ No
Heart disease? ☐ Yes ☐ No
Osteoporosis? ☐ Yes ☐ No
Ovarian cancer? ☐ Yes ☐ No
Uterine cancer? ☐ Yes ☐ No
Other cancers? ☐ 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 ____ Miscarriages ____ Abortions ____
Living children ____ Full-term live births ____ Premature births ____
Please list any other concerns: _____

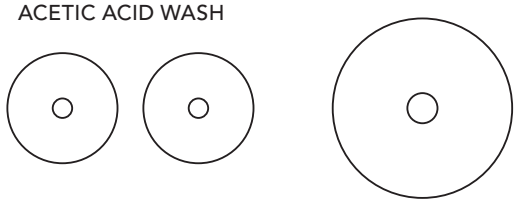
Physician section:

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

Nl	Abn		Nl	Abn	
☐	☐	HEENT	☐	☐	ABDOMEN
☐	☐	THYROID	☐	☐	SKIN
☐	☐	LUNGS	☐	☐	EXTREMITIES
☐	☐	HEART	☐	☐	NEURO

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

Nl	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
☐ STD screen ☐ Diet/Exercise ☐ HPV vaccine ☐ Tdap
☐ BSE info ☐ Flex sig ☐ Calcium ed ☐ Flu shot
☐ Mammogram _____ ☐ Dexa ☐ Heel ☐ Full

Return for pap/well woman: 1 year ____ 3 year ____ RTC ____

AMERICAN ACADEMY OF FAMILY PHYSICIANS

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