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?
    a. Calcium [Yes] [No]
    b. Estrogen (Premarin) [Yes] [No]
    c. 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  [ ] sometime  [ ] never

continued ➤
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 □ N/A □ Yes □ No had your cholesterol level checked in the past five years?
   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: _______

11. Please describe any concerns you have:

_________________________________________________________
_________________________________________________________
_________________________________________________________
_________________________________________________________
_________________________________________________________
_________________________________________________________
_________________________________________________________
_________________________________________________________

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? _______

Thank you for your help.
Name: ___________________________  DOB: ___________________  Chart #: ____________________  Date: ___________________

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Allergies

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  Abnormal: _____________________________________________________
(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 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: ________________________________________