Name:________________________________ **WELL-WOMAN EXAM** page 1 v2.6

To help your doctor during today's health exam, please complete items 1 through 14.

1. Number of times pregnant: ______

   Number of completed pregnancies: ______

   Date of last pregnancy: ______

   Are your menses regular? ☐YES ☐NO

   Do you have a vaginal discharge? ☐YES ☐NO

   What method of birth control do you use?_______________________________________

   If pills, how many years?______

   Are you planning a pregnancy in the next 6-12 months? ☐YES ☐NO

2. Do you take any of the following pills?

   Calcium ☐YES ☐NO
   Estrogen (Premarin) ☐YES ☐NO
   Progesterone (Provera) ☐YES ☐NO

3. Have you had any of the following problems:

   High Blood Pressure ☐YES ☐NO
   Heart Disease ☐YES ☐NO
   High Cholesterol ☐YES ☐NO
   Migraine Headaches ☐YES ☐NO
   Blood Clot in legs ☐YES ☐NO
   Cancer_______________ ☐YES ☐NO
   Other
   ____
   ____

   List surgeries: _____________________________________
   ____

4. When was your last Pap test? ________________________
   Any Abnormal Pap tests ☐YES ☐NO

   If yes what problem: __________________

   Have you have any of the following done?
   Colposcopy ☐YES ☐NO
   Biopsies ☐YES ☐NO
   Surgery ☐YES ☐NO

5. When was your last mammogram? ___________________
   Any abnormal mammograms ☐YES ☐NO

   If yes what problem: __________________

   Have you had any of the following done?
   Breast Biopsy ☐YES ☐NO
   Breast Cyst fluid drained ☐YES ☐NO
   Breast Surgery ☐YES ☐NO

6. 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. A new or enlarging lump in breast ☐YES ☐NO

   e. Change in size/firmness of stools ☐YES ☐NO

   f. Change in size/color of a mole ☐YES ☐NO

   g. Severe headaches ☐YES ☐NO

   h. Trouble falling or staying asleep ☐YES ☐NO

   i. Often feeling down, depressed or hopeless during the past month ☐YES ☐NO

   j. Often having little interest or pleasure in doing things during the past month ☐YES ☐NO

   k. Conflict in your family or relationships, sometimes handled by pushing, hitting or cruelty ☐YES ☐NO

7. Do you have a parent, brother, sister or close family member with any of the following:

   Breast Cancer, Colon Cancer, Uterine Cancer, Heart attacks, Diabetes, High cholesterol, High blood pressure, or other medical problems?

   If so explain:

   Mother: _____________________________________

   Father: _____________________________________

   Brother: _____________________________________

   Sister: _____________________________________

   Other: _____________________________________

   ____

   ____

Physician reviewed__________

Continues on Back

Name:______________________________________

8. Do you have **relatives** with the following:
   Stooping over or losing height as they got older, "thin bones," or hip fractures ☐YES ☐NO

   If yes, relation: ________________________

Have **you** had any of the following:
- Height loss ☐YES ☐NO
- Broken hip or wrist ☐YES ☐NO
- Bone-density test ☐YES ☐NO

Do you take thyroid medicine, seizure medicine, or steroids (prednisone), ☐YES ☐NO

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. Diet:
    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

11. Exercise:

    Type ______________________________________

    Days per week ________☐do not exercise

    Time/duration ________ minutes

    Exertion level: ☐stroll ☐mild ☐heavy

12. Have you ever used tobacco? ☐YES ☐NO
    Average number of packs/day:_______
    Number of years smoked:_______
    Year quit:__________

    When are you planning to quit?
    ☐now ☐next 6 months ☐sometime ☐never

13. Prevention
    Do you always wear seat belts? ☐YES ☐NO

    If over 30 years old, have you had your cholesterol level checked in the past five years? ☐YES ☐NO

    Have you had a tetanus shot in the past 10 years? ☐YES ☐NO

    Does your house have a working smoke detector? ☐YES ☐NO

    Do you have firearms at home? ☐YES ☐NO

    How many sexual partners have you had in the last 12 months? ____
    In your lifetime? ____

    When is the last time you had a dental check-up?________

14 Please describe any other concerns you have:
____
____
____
____
____
____
____
____
____
____
____
____
____
____

Thank you for your help.

WESTSHORE PRIMARY CARE

Physician reviewed__________

WELL-WOMAN EXAM v2.6

Name:_______________________________________

Age:___________**DOB:**_____________**Date:**___________

HPI:

HT________ **BP**___________ **P**_____ **R**_____ **T**_______

WT_______lb **BMI**________**LMP**_______ ☐**Med sheet rev.**

Allergies:

Chaperone:_______________ ☐patient declines

Exam	wnl	See note	
General			NAD, Cooperative
Skin			no Rash
HEENT			PERRLA, TMs clr, nl Mucosa
Neck			Supple, Thyroid nl
Heart			RRR without Mur/rub/thrill
Lungs			CTA bilat equal breath sounds
Abdomen			Soft, NT, nl BS, no Mass
Extremities			no Edema, nl Pulses
Psych			nl Affect
Neuro			Reflex =, nl Sensation, nl Gait
Lymph			no Adenopathy
Musc/skel			Strength equal, no Deformity
Vaginal			nl Rugae, no Lesions
Cervix			Smooth, Pink
Uterus/adnexa			no CMT, no Masses
Breasts			no Mass or Skin change
Rectal			nl Tone, no Mass, Heme neg

Assessment:

All patients:

☐Reinforced healthy diet, lifestyle, exercise and safety
☐Recommended Coated **ASA 81** mg/d
☐**Dental exam** recommended
Cholesterol: ☐screen ordered ☐rev. on chart__________
Blood screening ordered:
____
☐**Flu shot:** recommended ☐patient declines ☐**UTD**
☐**Gardasil:** recommended ☐patient declines ☐**UTD**
☐**Td/Adacil** recommended ☐patient declines ☐**UTD**
☐**Meningitis** vaccine rec. ☐patient declines ☐**UTD**
UTD for: ☐HepB ☐MMR ☐Varicella
Calcium: advised: ☐600mg/d ☐1200mg/d
☐**Pap** smear sent
☐ordered **Mammogram** ☐reviewed on chart ____________

Over 50 y/o:

☐EKG
☐Reminded to report postmenopausal bleeding
Colon cancer screen: ☐colonoscopy
☐stool guaiac x 3 cards given
☐Bone density Dexa ordered (>60 if risk present)
☐Pneumovax (>65 y/o) recommended ☐patient declines
☐Zostavax recommended ☐patient declines

Follow up: ________ days/weeks/months/year

Physician signature: ___________________________________