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 ❍ sometime ❍ never

Form continues on next page ➤

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:

____
____
____
____
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____
____
____
____

Thank you for your help.

continued ➤

WELL-WOMAN EXAM

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 R_x
- ❍ Calcium R_x: ❍ 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)

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)

Follow-Up: ❍ Routine visit in ____________________ for ____________________ ❍ Physical exam in __________

Name: ____

DOB: ______/______/______

Chart #: ________________

Physician signature: ____________________________________

Physician name: ______________________________________

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Cardinal PA. *Family Practice Management.* July/August 2003:35-40, www.aafp.org/fpm/20030700/35enco.html.

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