Female Exam

TO HELP YOUR DOCTOR DURING TODAY'S HEALTH EXAM, PLEASE COMPLETE ITEMS 1 THROUGH 14:

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? ❑ Yes ❑ No
in the next 6-12 months? ❑ Yes ❑ No

3. Do you take any of the following pills?

Multi Vitamin ❑ Yes ❑ No
Calcium supplement ❑ 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/ 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 or firmness of stools? ❑ Yes ❑ No

5. Do you have any of the following? *(continued)*

g. Change in size or 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
n. Difficulty with holding your urine? ❑ Yes ❑ No
o. Periods of weakness, numbness, or inability to talk? ❑ Yes ❑ No
p. Problems with dizziness? ❑ Yes ❑ No
q. Problems with hearing or vision? ❑ 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 age 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 stooping over or losing height as they got older, "thin bones," or 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

QUESTIONS CONTINUE ON BACK ▸

____
____
____
____
____

Name ____/ DOB _______________________Date ______________________

Female Exam

8. Have you ever used tobacco? ❑**Yes** ❑**No**

If yes, average number of packs/day: ___________

Number of years you smoked: ________ Year you quit: _________

When are you planning to quit?

❑ Now ❑ Next 6 months ❑ Sometime ❑ Never

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 & Starches	❑ Few	❑ Some	❑ A lot
Vegetables & Fruits	❑ Few	❑ Some	❑ A lot
Dairy Foods	❑ Few	❑ Some	❑ A lot
Meats	❑ Few	❑ Some	❑ A lot
Sweets	❑ A lot	❑ Some	❑ Few

b. Exercise

Activity ____

Days per week_______________

Time/duration _______________ in minutes

Exertion: ❑ Stroll ❑ Mild ❑ Moderate ❑ Heavy

c. Do you always wear seat belts? ❑ No ❑ Yes

d. Do you always wear bike helmets? ❑ No ❑ Yes

e. If over 20 years old, have you had your cholesterol level checked in the past five years? ❑ No ❑ Yes

f. Have you had the following shots?:

Tetanus ❑ No ❑ Yes When? _________________

Pneumonia ❑ No ❑ Yes When? _________________

Flu ❑ No ❑ Yes When? _________________

g. Does your house have a working smoke detector? ❑ No ❑ Yes

h. Does your house have a working fire estinguisher? ❑ No ❑ Yes

i. Do you have firearms at home? ❑ Yes ❑ No

10. Prevention: ***(continued)***

j. Have you ever had a mammogram? ❑ No ❑ Yes

If yes, date of last: _____________ where: _________________

Have you ever had any abnormal mammograms? ❑ 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

k. How many sexual partners have you had in the last 12 months? _________ In your lifetime? __________

l. Have you ever had a sexually transmitted disease ❑ Yes ❑ No

If yes, explain ____

m. When was your last dental check-up? ____________________

n. When was your last eye exam? _________________________

o. Have you ever had a colonoscopy, barium enema, or flexible sigmoidoscopy? ❑ No ❑ Yes

If yes, What? __________________ When? ___________________

Result ____

11. Are there any health changes in your family history?

Father: ____

____

____

Mother: ____

____

____

Siblings:____

____

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____

____

12. Please list any new medications ***(prescription or over-the-counter)*****, vitamins, herbals, or supplements:**

____

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____

PROVIDER USE ONLY:

❑**Meds reviewed/updated** ❑**Face sheet updated**

Name____ Date______________________________

Female Exam

HEIGHT	WEIGHT	BMI	BP

IF NECESSARY				ALLERGIES
TEMP	PULSE	RESP	O_2 SAT	❏ NKDA

Nurse initial/signature ______________________

OTHER COMPLAINTS / HPI

PROBLEM SUMMARY LIST (REVIEWED/UPDATED) _____ (initials)

____

____

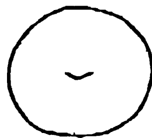
____

PHYSICAL EXAM: As indicated by past medical history

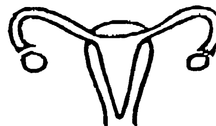
HEENT: Normal Abnormal: ______________________
Heart: Normal Abnormal: ______________________
Lungs: Normal Abnormal: ______________________
Rectum: Normal Abnormal: ______________________
Abdomen: Normal Abnormal: ______________________
Skin: Normal Abnormal: ______________________
Extremities: Normal Abnormal: ______________________
Neurological: Normal Abnormal: ______________________
Musculo-skeletal: Normal Abnormal: ______________________
Vaginal: Normal Abnormal: ______________________

EXT. GENITALIA & URETHRAL MEATUS
Normal Abnormal

CERVIX
Normal Abnormal

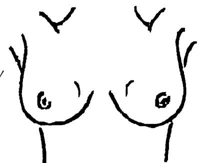


UTERUS AND ADNEXA
Normal Abnormal



BREASTS
Normal Abnormal

(No masses; no skin, nipple or axillary changes)



DIAGNOSES ❐ V70.0 ❐ V72.3: ______________________

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PLAN: All Patients:
- ❐ Discussed and reinforced healthy diet, lifestyle, exercise and safety
- ❐ Pap Smear ❐ GC/Chlamydia if < 26yo
- ❐ Calcium Rx: ❐ 1000 mg/d ❐ 1500 mg/d
- ❐ Vitamin D: ❐ 400 iu/d ❐ 800 iu/d
- ❐ Immunizations: Flu, Tdap, HPV if < 26yo
- ❐ Recommended Dental Exam
- ❐ Recommended Eye Exam
- ❐ Fasting lipids ❐ Fasting glucose
- ❐ Other __________________ ❐ TSH ______________________

Over 40 yrs. old
- ❐ Mammogram (controversial 40-50 y/o consider q 2 yrs.)

Over 50 yrs. old
- ❐ Reminded to report postmenopausal bleeding
- ❐ Colon Cancer Screen:
  - ❐ Colonoscopy ❐ ACBE
  - ❐ Flex Sig ❐ IFOB
- ❐ Bone density
- ❐ Coated ASA: ❐ 81 mg/d
- ❐ Immunizations: pneumococcal (>65 yrs. old)

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- ❐ See Dictation

FOLLOWUP: ❐ **Patient Name** ______________________ ❐ **DOB** ______________

❐ Routine Visit in ________________ for ______________________

❐ Physical Exam in ________________ Physician Sig______________________ Date __________