WOMAN - COMPLETE PHYSICAL/PREVENTION NAME: DATE:

To help your doctor during today's health exam, please complete items 1 through 10.

1. Age: _____

2. Have you had any of the following problems:
   a. High blood pressure, heart disease, diabetes, or high cholestorol: □ YES □ NO

   b. Cancer: □ YES □ NO

3. Do you have any of the following problems:
   a. Bothersome joint pain; pain in the muscles: □ YES □ NO

   b. Change in size/firmness of stools; diarrhea, constipation: □ YES □ NO

   c. Change in size/color of a mole: □YES □ NO

   d. Sleeping poorly or having any trouble falling or staying asleep during the past month: □ YES □ NO

   e. Severe headaches: □ YES □ NO

   f. Often feeling down, depressed or hopeless during the past month: □ YES □ NO

   g. Often having little interest or pleasure in doing things during the past month: □ YES □ NO

   h. Chest pain, shortness of breath; palpitations: □ YES □ NO

   i. Stomach problems or heartburn; nausea: □ YES □ NO

   j. Problems with falling or doing routine tasks at home: □ YES □ NO

   k. Periods of weakness, fatigue, numbness inability to talk or dizziness: □ YES □ NO

   l. Migraine headaches, blood clots in legs: □ YES □ NO

   m. Abdominal or pelvic surgery or special tests: □ YES □ NO

   n. Conflict in your family or relationships, sometimes handled by pushing, hitting or cruelty (abuse): □ YES □ NO

4. 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 50: □ YES □ NO

   c. Diabetes: □ YES □ NO

If yes to a, b or c:
Relation: _____ Type: _____

Relation: _____ Type: _____

5. Have you ever smoked: □ 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
   Have you been diagnosed with asthma/ COPD(Emphysema): □ YES □ NO
   Do you have cold feet, claudication: □ YES □ NO

6. 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

7. Prevention:
   a. Which of the following are included in your diet:

Cereals / fibers	□ a lot	□ some	□ few
Vegetables/fruits	□ a lot	□ some	□ few
Dairy foods	□ a lot	□ some	□ few
Meats	□ a lot	□ some	□ few
Sweets/starches	□ 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 (guns) at home: □ YES □ NO

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

   i. When is the last time you had a dental check-up:_____

Form continues on next page >

WOMAN - COMPLETE PHYSICAL/PREVENTION

8. 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, □ YES □ NO
seizures or thin bones □ YES □ NO

OB-GYN

9. Number of times Pregnant _____
Number of completed pregnancies_____
Date of last pregnancy _____
Pregnant now □YES □ NO
Do you use any method of birth control □YES □ NO
If pill, what kind?_____
Any problem with it? _____
How many years have you used the pill? _____
Date of last PAP _____

Have you had any 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

If still menstruating, answer the next questions:
a.First day of last menstrual period _____
b.Are your periods regular? _____painful _____
c.Do you bleed a lot during your periods? _____
d. Are you planning a pregnancy in the next 6 – 12 months □ YES □ NO
Any urinary problem, incontinence □ YES □ NO

If menopaused:
a. Had you any bleeding since periods stopped?_____
b. Do you take any of the following:
Calcium □ YES □ NO
Hormones □ YES □ NO

CONTINUED

c. Do you have hot flashes, mood swings? □ YES □ NO
d. Do you have dryness, vaginal itching? □ YES □ NO
e. Do you have pain with intercourse? □ YES □ NO
f. Any vaginal odor, itch or discharge? □ YES □ NO
g. Any problem with interest in or enjoying intercourse? □ YES □ NO
h. Any new or enlarging lump in the breast? _____

10. Please describe any concerns you have:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Thank you for your help.

FEMALE PHYSICAL EXAM

Weight/BMI	Height	Abd. Circumf.	BP	Temp	Pulse	Resp	O2 Sat	Allergies

☑ Examined and WNL ☒ Abnormal

M.A.

Skin ☐

HEENMT ☐

Neck/Thyroid ☐

Spine ☐

Chest/Lungs ☐

CV/Heart ☐

Abdomen ☐

Lymph Nodes ☐

Genitourinary/Rectum ☐

MSK/Extremities ☐

Peripheral Vascular ☐

Neuro System ☐

Psych. ☐

Diagnosis:

Plan:

All patients:

- ☐ Handout given and reinforced healthy diet, lifestyle, exercise and safety
- ☐ Pap smear
- ☐ Calcium Rx: ☐ 600mg/d ☐ 1200mg/d
- ☐ Immunizations: flu, Td/P (q 10 yrs)
- ☐ Recommended dental exam

Over 50 y/o

- ☐ Remind to report postmenopausal bleeding
- ☐ Cholesterol
- ☐ Hormone replacement
- ☐ Colon cancer screen: ☐ colonoscopy ☐ stool guaiac X3
- ☐ Bone densitometry
- ☐ BB ASA, 81 mg/d
- ☐ Immunizations: pneumococcal (>65 y/o)
- ☐ Mammogram q 1 yr
- ☐ Flu Vaccination q 1 yr

Over 40 y/o:

- ☐ Mammogram (40-50 y/o, consider q 2 yrs)

☐ Return to office: Days _____Week(s)_____Month(s)_____ ☐PRN

☐ Referral

Physician signature: _____Date: _____