



# Well-Female Exam

Patient Name: \_\_\_\_\_

MRN: \_\_\_\_\_

**BAY VALLEY  
MEDICAL GROUP**

To help your doctor during today's 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 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, 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 tests  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

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	<input type="radio"/> a lot	<input type="radio"/> some	<input type="radio"/> few
Vegetables	<input type="radio"/> a lot	<input type="radio"/> some	<input type="radio"/> few
Dairy foods	<input type="radio"/> a lot	<input type="radio"/> some	<input type="radio"/> few
Meats	<input type="radio"/> a lot	<input type="radio"/> some	<input type="radio"/> few
Sweets	<input type="radio"/> a lot	<input type="radio"/> some	<input type="radio"/> 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?  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	<input type="radio"/> YES	<input type="radio"/> NO
Cyst fluid drained	<input type="radio"/> YES	<input type="radio"/> NO
Surgery	<input type="radio"/> YES	<input type="radio"/> 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 completing this form.*