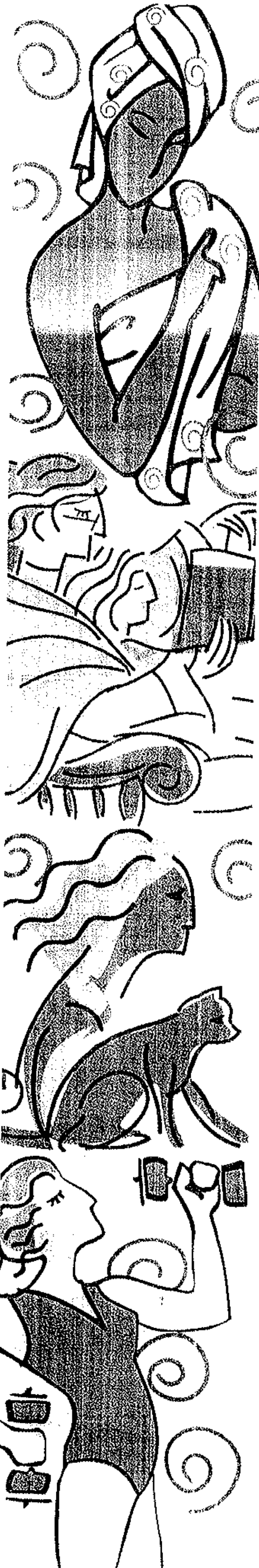

# Women's Health Update

Date________________________ ID#________________________

Name________________________ Date of Birth____________ Age______

Address________________________________________________

Home Phone____________________ Work Phone____________________

Insurance changes________________________________________

Reason for visit__________________________________________

Allergy changes since last visit___________________________

Medication changes since last visit________________________

Major life changes (death of family member, loss of job, etc.) since last visit____________

________________________________________________________

Date of last menstrual period______________ Date of last Pap smear______________

## Symptoms Checklist

Have you experienced any of the following symptoms recently?

- ☐ Changes in moles
- ☐ Depressed mood
- ☐ Digestive problems
- ☐ Hot flashes
- ☐ Increased vaginal discharge
- ☐ Lumps
- ☐ Painful intercourse
- ☐ Shortness of breath
- ☐ Unpleasant vaginal odor
- ☐ Vaginal itching or burning

Other________________________________

________________________________

________________________________

## Breast Health

Date of last mammogram________________

Do you do breast self-exams every month?

☐ Yes ☐ No

Have you noticed any nipple discharge?

☐ Yes ☐ No

Have you noticed any lumps or other irregularities in your breasts? ☐ Yes ☐ No

If yes, please explain________________

________________________________

________________________________

## Birth Control Update

Are you sexually active? ☐ Yes ☐ No

What method of birth control do you currently use?________________

## Lifestyle Issues

Check which issues apply to you and indicate the frequency of occurrence: occasional, daily, or throughout the day

- ☐ Caffeine use________________
- ☐ Street drug use________________
- ☐ Tobacco use________________
- ☐ Unusual stress________________
- ☐ Heavy lifting________________
- ☐ Chemical exposure________________
- ☐ Other________________

Do you take calcium supplements?

☐ Yes ☐ No

What is your level of exercise?

☐ Good ☐ Fair ☐ Poor

Describe________________

________________________________

________________________________

I certify that I have answered the questions on this form to the best of my knowledge.

Patient Signature________________

Date________________

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# EXAM (For office use only)

## General

General appearance_______________

_______________

Height _______________

Weight _______________

Blood pressure _______________

Temp _______________

Pulse _______________

Respiration _______________

Eyes, Ears _______________

Nose, Throat _______________

Heart _______________

Lungs _______________

Abdomen _______________

Back _______________

Urine _______________

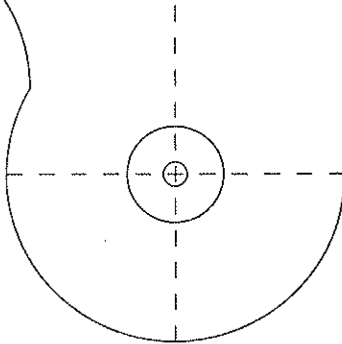
Blood _______________

Other Lab _______________

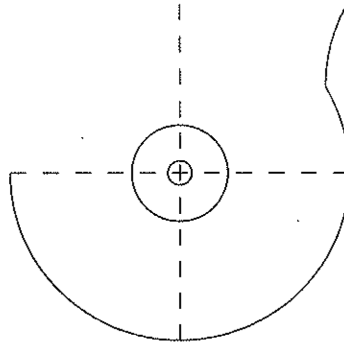
_______________

## Breast Exam

**Right** ☐ Normal



**Left** ☐ Normal



Comments:

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R _______________ L _______________

## Pelvic Exam

Vulva _______________

Bladder and Urethra _______________

Vulvo-Vaginal Glands _______________

Introitus _______________

Perineum _______________

Vagina _______________

Cervix _______________

Uterus _______________

Adnexa: R _______________ L _______________

Cul-de-sac _______________

Rectal _______________

**Assessment** _______________

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**Plan** _______________

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Physician's Signature _______________ Date _______________