Name: ____ Date: _________________

FEMALE EXAM

Last Menstrual Period ___ /___ /_____ Last Pap Smear ____ /_____
Last Mammogram ____ /____

Please circle your responses.

Do you plan on a *well woman exam* (breast, pap & pelvic only), a *physical* (the rest of your body) or *both*?

<u>Review Of Systems</u>: Any current problems with:

cough	yes/no	changing moles	yes/no
breast lumps/discharge	yes/no	hay fever	yes/no
rectal bleeding	yes/no	menstrual problems	yes/no
chest pain	yes/no	bladder leakage	yes/no
vaginal discharge	yes/no	shortness of breath	yes/no
depression	yes/no	hot flashes	yes/no
hearing problem	yes/no	vision problem	yes/no
sleep problem	yes/no		

Do you wear a seatbelt?	yes/no	Do you wear sunscreen?	yes/no
Do you wear sunglasses?	yes/no	Do you exercise?	yes/no
Do you do a breast exam?	yes/no	If yes, how often? _____________	
Do you drink caffeine?	yes/no	Do you eat healthily?	yes/no

When was your last dental exam? ___/___ your last eye exam? ___/___
your last Tetanus shot? ___/____

If 50 years old or more, have you had: a pneumonia vaccine Y/N, EKG Y/N, chest X-ray Y/N, colonoscopy Y/N

How many babies have you had? ____ How many pregnancies total? ______

Have you ever had an abnormal pap? yes/no If yes, when? _____ How treated? cone biopsy/cryo/no treatment

Have you ever had a sexually transmitted disease? yes/no If yes, was it treated? Yes/no
How many sexual partners have you had in your life? 4 or less / 5 or more
Do you feel safe at home? yes/no Have you ever been abused? yes/no

What form of birth control do you use? Not App / vasectomy / hysterectomy / tubes tied / birth control pills / Depo-Provera / condoms / diaphragm

Other problems? (these should be addressed at another appointment):______________________