



WELL-WOMAN EXAM

To help your doctor during today's health 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? _____
 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 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 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: _____

Form continues on next page >



7. Osteoporosis (thin-bone) screening:

- a. Is there a history of any relatives with the following: YES NO
 stooping over or losing height as they got older, "thin bones," hip fractures

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

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="checkbox"/> a lot | <input type="checkbox"/> some | <input type="checkbox"/> few |
| Vegetables | <input type="checkbox"/> a lot | <input type="checkbox"/> some | <input type="checkbox"/> few |
| Dairy foods | <input type="checkbox"/> a lot | <input type="checkbox"/> some | <input type="checkbox"/> few |
| Meats | <input type="checkbox"/> a lot | <input type="checkbox"/> some | <input type="checkbox"/> few |
| Sweets | <input type="checkbox"/> a lot | <input type="checkbox"/> some | <input type="checkbox"/> 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="checkbox"/> YES | <input type="checkbox"/> NO |
| Cyst fluid drained | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Surgery | <input type="checkbox"/> YES | <input type="checkbox"/> NO |



Madison Medical Associates, P.C.
David T. Fletcher, M.D.
1075 S. Main Street Suite 100
Madison, GA 30650

Name _____

Medical Record# _____ Page# _____

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:

Thank you for your help. **Form continues on next page >**

