



Preventative Wellness Exam – Adult Female

Patient Name

| Constit | utional | | Muscul | oskeletal | | | |
|---------------|--------------|--|----------------------|------------|---|--|--|
| ☐ Yes | ☐ No | Chills | ☐ Yes | □ No | Back Pain | | |
| ☐ Yes | □ No | Fatigue | ☐ Yes | □ No | Muscle Pains | | |
| ☐ Yes | □ No | Fever | | | | | |
| ☐ Yes | ☐ No | Night Sweats | Integumentary/Breast | | | | |
| ☐ Yes | □ No | Victim-Domestic Violence | ☐ Yes | □ No | Rashes | | |
| ☐ Yes | □ No | Weight Gain (unintentional) | ☐ Yes | □ No | Breast Mass | | |
| ☐ Yes | □ No | Weight Loss (unintentional) | ☐ Yes | □ No | Breast Skin Changes | | |
| | | , | ☐ Yes | □ No | Breast Tenderness | | |
| Eyes | | | ☐ Yes | □ No | Nipple Discharge | | |
| \square Yes | □ No | Eye Pain | ☐ Yes | □ No | Self Breast Exams? | | |
| \square Yes | □ No | Glasses/Contact | | | | | |
| | | | Neurological | | | | |
| Ears/N | ose/Throat | | ☐ Yes | ☐ No | Dizziness | | |
| \square Yes | ☐ No | Ear Pain | ☐ Yes | ☐ No | Fainting | | |
| ☐ Yes | ☐ No | Frequent Nose Bleeds | ☐ Yes | ☐ No | Headaches | | |
| \square Yes | ☐ No | Bleeding Gums | \square Yes | ☐ No | Weakness | | |
| \square Yes | ☐ No | Oral Gum Disease | | | | | |
| \square Yes | ☐ No | Dentures Present | | ologic /Ly | · · | | |
| | | | ☐ Yes | ☐ No | Easy Bruising | | |
| Cardio | vascular | | ☐ Yes | ☐ No | Excessive Bleeding | | |
| ☐ Yes | ☐ No | Chest Pain | ☐ Yes | ☐ No | Hx of Blood Transfusion | | |
| ☐ Yes | ☐ No | Dizziness | | | | | |
| ☐ Yes | ☐ No | Heart Palpitations | Endocri | | | | |
| ☐ Yes | ☐ No | Racing Heartbeat | ☐ Yes | □ No | Hair Loss | | |
| | | | ☐ Yes | □ No | Heat/Cold Intolerance | | |
| Respira | | | ☐ Yes | □ No | Excessive Facial or Body Hair | | |
| ☐ Yes | □ No | Cough (acute) | ☐ Yes | □ No | Hot Flashes | | |
| ☐ Yes | □ No | Cough (chronic) | ☐ Yes | □ No | Infertility | | |
| ☐ Yes | ☐ No | Shortness of Breath | Allavaia | /1 | Jagia | | |
| Gastro | intestinal | | ☐ Yes | /Immuno | Seasonal Allergies/"Hayfever" | | |
| ☐ Yes | □ No | Abdominal Pain | □ Yes | □ No | Perennial Allergies | | |
| □ Yes | □ No | Bloating | □ 1es | □ NO | Pereninal Allergies | | |
| □ Yes | □ No | _ | Genitou | ırinarv | | | |
| □ Yes | _ | Constipation Diarrhea | ☐ Yes | □ No | Painful Menstrual Cycle | | |
| □ Yes | □ No □ No | Heartburn | □ Yes | □ No | Pain With Intercourse | | |
| □ Yes | □ No | | □ Yes | □ No | Pain With Urination | | |
| □ Yes | □ No | Black Stool | □ Yes | □ No | Genital Lesions | | |
| □ Yes | □ No | Nausea | □ Yes | □ No | Blood In Urine | | |
| □ Yes | □ No | Vomiting Stool Caliber Change | □ Yes | □ No | High Risk Sexual Behavior | | |
| ⊔ res | □ INO | Stool Caliber Change | □ Yes | □ No | Irregular Menstrual Cycle | | |
| Psychia | atric | | | □ No | Heavy Menstrual Cycles | | |
| ☐ Yes | | Anxiety | | □ No | Frequent Awakening At Night to Urinate | | |
| ☐ Yes | □ No | Crying Spells | □ Yes | □ No | Post-Coital Vaginal Bleeding | | |
| ☐ Yes | □ No | Depression | □ Yes | □ No | Post-Menopausal Bleeding | | |
| ☐ Yes | □ No | Feeling Stressed | □ Yes | □ No | Rape (history of) | | |
| □ Yes | □ No | Loss of Interest in Pleasurable Activities | □ Yes | □ No | Sexual Abuse | | |
| ☐ Yes | □ No | Mood Swings | ☐ Yes | □ No | Urinary Incontinence | | |
| □ Yes | □ No | PMS | ☐ Yes | □ No | Vaginal Discharge | | |
| ☐ Yes | □ No | Recreational Drug Use | ☐ Yes | □ No | Vaginal Bischarge Vaginal Itch | | |
| ☐ Yes | □ No | Sleep Disturbance | | | · O · · · · · · · · · · · · · · · · · · | | |
| ☐ Yes | □ No | Suicidal Thoughts | | | | | |



cancer in your family.

Family Cancer History Questionnaire

| Patient Name | Date of Birth | Age |
|-------------------------|---------------------|-----|
| Today's Date (MM/DD/YY) | Healthcare Provider | |

You and the following close blood relatives should be considered: You, parents, brothers, sisters, daughters, grandparents, aunts, uncles, nephews, nieces, half-siblings, first-cousins, great-grandparents and great grandchildren.

You and Your Family's Cancer History (Please be as thorough and accurate as possible)

| | | | | | | 1 | 1 | 1 |
|-----|---------------------------------|-----------|----------|-----------|-----------|-----------|-------------|-----------|
| | | YOU | Parents | Age at | Maternal | Age at | Paternal | Age at |
| Y/N | CANCER | Age at | Siblings | Diagnosis | Relatives | Diagnosis | Relatives | Diagnosis |
| | | Diagnosis | Children | | | | | |
| | | 45 | | | Aunt | 45 | Half-Sister | 53 |
| Υ | Example: Breast Cancer | | | | Cousin | 61 | | |
| | Breast Cancer | | | | | | | |
| | (Female or Male) | | | | | | | |
| | | | | | | | | |
| | Ovarian Cancer | | | | | | | |
| | Uterine Cancer | | | | | | | |
| | (Endometrial) | | | | | | | |
| | Colon/Rectal Cancer | | | | | | | |
| | 10 or more Lifetime Colon | | | | | | | |
| | Polyps (Specify #) | | | | | | | |
| | Other (Consider a second second | | | | | | | |
| | Other (Specify cancer type) | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| L | | l l | | l | | l . | 1 | |

| □ Yes | □ No | Are you of Ashkenazi Jewish descent? |
|-------|------|---|
| □ Yes | □No | Are you concerned about personal and/or family history of cancer? |
| □ Yes | □No | Have you or anyone in your family had genetic testing for a hereditary cancer syndrome? (Please explain/include a copy of result, if possible). |





Preventative Wellness Exam – Adult Female

Based on American College of Obstetrics and Gynecology and insurance standards, preventative office visits are routine well patient evaluations. Preventative well woman exams consist of health history, medication history, a physical exam with breast exam, pap smear, bimanual uterine/ovary exam (as indicated), urinalysis, and routine blood work (as indicated).

If an abnormality is encountered or a pre-existing problem is addressed in the process of performing this exam, you may be charged an additional fee/co-pay based on your insurance benefits. All visit information is sent electronically to your insurance company and you will be responsible for any additional fees as determined by your insurance benefits.

| Patient Name | |
|--------------|------|
| | |
| Signature | |