The Physicians Center for Wellbeing — Well-Woman Exam

1140 S Linden Road
Flint, Michigan 48532
Phone: 810 732-3180
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Name: _____ **Age:** _____ **Date:** _____

Vital Signs: HT _____ **WT** _____ **BP** _____/_____ **ALL** _____ **Meds Rev: No change** ☐ **Refills** ☐

Smoker ➔ ☐ Amount: _____

When was your last Pap test? ☐1 yr ☐2 yr ☐>3 yr
Were the results normal? ☐Yes ☐No
Have you ever had an abnormal Pap test? ☐Yes ☐No
Have you ever had Cryocautery/LEEP/LETZ? ☐Yes ☐No

When was your last period? _____
How often do you usually get your period? Every _____ days
Are your periods usually regular? ☐Yes ☐No
How many days do your periods usually last? _____ Days
Blood flow is: ☐Light ☐Moderate ☐Heavy
Do you have any bleeding between periods? ☐Yes ☐No

If menopausal, was it: ☐Natural ☐Surgical
Were your ovaries left? ☐Yes ☐No
Do you have hot flashes? ☐Yes ☐No
Are you on hormone replacement? ☐Yes ☐No

Do you have any vaginal discharge? ☐Yes ☐No
Are you sexually active? ☐Yes ☐No
If yes, do you and your partner use birth control? ☐Yes ☐No
Method: _____
Have you ever had a sexually transmitted disease? ☐Yes ☐No

Do you perform self-breast exams? ☐Yes ☐ No
How often: ☐Less often than monthly ☐
Do you have history of breast problems? ☐Yes ☐No

Have you ever had a mammogram? ☐Yes ☐No
If yes, date of last: _____ Where? _____
Have you ever had any abnormal mammograms?
If yes, date: _____ Problem: _____
For abnormality, did you have any of the following?
Biopsy ☐Yes ☐No
Cyst fluid drained ☐Yes ☐No
Surgery ☐Yes ☐No

Is there any family history of?

Breast cancer?	☐Yes ☐No	Osteoporosis?	☐Yes ☐No
Colon cancer?	☐Yes ☐No	Heart disease?	☐Yes ☐No
Uterine cancer?	☐Yes ☐No	Heart attacks?	☐Yes ☐No
Ovarian cancer?	☐Yes ☐No	Other cancer?	☐Yes ☐No
		Type: _____	

When was your last:
Dental check up _____Eye exam_____
Bone Density _____Colonoscopy_____
Stress Test _____

On a scale of 0-10, with 0 being no symptoms and 10 being severe,
How would you describe the following: (Please Circle?)
Pain during your usual period: 0 1 2 3 4 5 6 7 8 9 10
Pain during sex: 0 1 2 3 4 5 6 7 8 9 10
PMS (premenstrual syndrome): 0 1 2 3 4 5 6 7 8 9 10

Are you currently pregnant? ☐Yes ☐No
Are you planning pregnancy in the next 6-12 months? ☐Yes ☐No
If you have been pregnant, please indicate how many:
Pregnancies: _____ Full-term live births: _____
Premature births: _____ Abortions: _____ Living Children: _____

Is conflict in your family or relationships sometimes handled by pushing, hitting or cruelty? ☐Yes ☐No

Have you ever used tobacco? ☐Yes ☐No If yes:
Average number of packs per day: _____
Number of years smoked: _____
Year quit: _____
Are you planning to quit?
☐Now ☐Next time ☐Sometime ☐Never

Do you drink alcohol? ☐Yes ☐No
If yes, have you ever:
Felt you should cut down on your drinking? ☐Yes ☐No
Been annoyed by people nagging about the drinking? Yes ☐No
Felt guilty about your drinking? ☐Yes ☐No
Had a drink first thing in the morning to steady your nerves or get rid of a hangover? ☐Yes ☐No

Prevention:
Which of the following are included in your diet?

Grains and starches	☐a lot	☐some	☐few
Vegetables	☐a lot	☐some	☐few
Dairy foods	☐a lot	☐some	☐few
Meats	☐a lot	☐some	☐few
Sweets	☐a lot	☐some	☐few

Exercise:
Activity: _____
Days per week: _____
Time/duration: _____
Exertion: ☐stroll ☐mild ☐heavy

Do you always wear seatbelts: ☐Yes ☐No?
If over 30 years old, have you had your cholesterol level checked in the past five years? ☐Yes ☐No
Have you had a tetanus shot in the past 10 years? ☐Yes ☐No
Does your house have a working smoke detector? ☐Yes ☐No
Do you have firearms at home? ☐Yes ☐No

Please list any other concerns:

_____

_____

_____

Physician's initials: _____ Revision date: 4-30-15

The Physicians Center for WellBeing

REVIEW OF SYSTEMS

Board Certified Family Practice
1140 S Linden Rd
Flint, Michigan 48532

NAME:_____ **AGE:** _____ **DATE:** _____

Do you have…….Check (x) either yes or no	Yes	No	**Check (x) either yes or no**	Yes	No
GENERAL:			**GU:**		
Normal activity/energy level			Penile discharge (Male only)		
Change in appetite			Frequent urination during the night		
Major weight gain			Difficulty with urination		
Major weight loss			Pain with urination		
Feel uneasy/out of sorts			Blood in urine		
Chills			Difficulty with urine stream strength or flow		
Fever					
Sweating			**MUSCULOSKELETAL:**		
			Muscle or joint pain		
			Weakness		
EYES:			Swelling		
Vision changes			Inflammation		
Double vision			Restriction of motion		
			Loss of muscle		
EARS/NOSE/MOUTH/THROAT:			Backache		
Buzzing/ringing in ears					
Hearing loss			**NEUROLOGICAL:**		
Gum bleeding			Weakness		
Nosebleeds			Dizziness		
Hoarseness			Loss of consciousness		
Difficulty swallowing			Stroke/TIA/Numbness		
Sinus congestion			Seizures		
Sinus pain			**Headaches**		
			SKIN/BREAST:		
RESPIRATORY:			Rashes		
Recent upper respiratory infections			Non-healing lesions		
Shortness of breath			Breast problems		
Cough			Change in size or color of mole		
Coughing or spitting up blood					
Wheezing			**PSYCHIATRIC:**		
			Increased nervousness		
			Mood changes		
CARDIAC:			Coping well		
Chest pain			Trouble falling or staying asleep		
Palpitations					
Difficulty breathing when lying down			**ENDOCRINE:**		
Shortness of breath with activity			Thyroid problems		
Sudden shortness of breath sleeping			Heat or cold intolerance		
			Diabetes		
			Excessive thirst or hunger		
GI:			Excessive urination		
Any food intolerance					
Abdominal pain			**HEMATOLOGIC/LYMPHATIC:**		
Nausea			Anemia		
Vomiting			Easy bruising		
Bloating			Bleeding		
Heartburn/indigestion			Swollen nodes		
Diarrhea					
Constipation			**ALLERGIC/IMMUNOLOGIC:**		
Black or tarry stools			Hay fever		
Blood in stools			History of environmental allergies		
Change in bowel consistency			Chronic problems with immunity		