GWINNETT CLINIC

WOMEN'S WELLNESS VISIT

Date: _____
Location: _____
Physician/NP: _____

PATIENT SECTION

Patient Name: _____ Date of Birth: _____
Age: _____ Race: _____ Marital Status: ☐ Single ☐ Married ☐ In a Relationship ☐ Divorced ☐ Widowed

MENSTRUAL HISTORY

When was your last period? ___/___/___ ☐ N/A Hysterectomy (Year ____) ☐ N/A Postmenopause
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 Do you have any bleeding between periods? ☐ Yes ☐ No

GYNECOLOGICAL, OBSTETRICS & BREAST HISTORY

Have you ever been sexually active? ☐ Yes ☐ No With: ☐ Males ☐ Females How many lifetime partners? _____
Do you use birth control? ☐ Yes ☐ No If yes, what do you use? _____

Total pregnancies: Full term _____ Preterm _____ Abortions/Miscarriages _____
How many children do you have? _____ What are the age(s) and gender(s)? _____

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

When was your last mammogram? ___/___/___ ☐ None Were the results normal? ☐ Yes ☐ No
Have you ever had a bone density scan (DEXA)? If yes, when? ___/___/___ Results:

Is there any family history of:

Breast cancer ☐ Yes ☐ No If yes, who? _____ Osteoporosis ☐ Yes ☐ No If yes, who? _____
Ovarian cancer ☐ Yes ☐ No If yes, who? _____ Cervical cancer ☐ Yes ☐ No If yes, who? _____
Uterine cancer ☐ Yes ☐ No If yes, who? _____ Colon cancer ☐ Yes ☐ No If yes, who? _____

DO YOU HAVE ANY OF THE FOLLOWING SYMPTOMS?

☐ Breast lump, pain ☐ Vaginal pain, discharge, odor ☐ Heavy or irregular periods ☐ Pain with sex ☐ Hot flashes

GENERAL HISTORY

Do you have a history of smoking? ☐ Yes ☐ No How often do you drink alcohol? _____
Do you take other medications? ☐ Yes ☐ No See attached or List: _____
Do you have any medication allergies? ☐ Yes ☐ No If yes, to what? _____

PHYSICIAN SECTION

VITAL SIGNS

TEMP _____
BP _____
PULSE _____
HT _____
WT _____
BMI _____
RR _____

PHYSICAL EXAM (Please check if normal findings. If abnormal findings, describe and circle the specific one(s))

HEENT	☐ Normal	☐ Abnormal	_____
LUNGS	☐ Normal	☐ Abnormal	_____
HEART	☐ Normal	☐ Abnormal	_____
ABDOMEN	☐ Normal	☐ Abnormal	_____
BREASTS	☐ Normal	☐ Abnormal	Masses | Lumps | Tenderness | Asymmetry | Nipple Discharge | Axilla
EXTERNAL GENITALIA	☐ Normal	☐ Abnormal	_____
UTERUS	☐ Normal	☐ Abnormal	_____
VAGINA	☐ Normal	☐ Abnormal	Appearance | Discharge | Lesions _____
CERVIX	☐ Normal	☐ Abnormal	Appearance | Discharge | Lesions _____

OTHER _____

TESTS REVIEWED: ☐ Urine dip _____ ☐ Urine pregnancy _____

ASSESSMENT/PLAN: ☐ Normal gyn ☐ Abnormal gyn with office visit | ☐ Pap only (age 21-29) ☐ Pap with HPV (age 30+)
☐ Mammogram ☐ Bone density ☐ Colonoscopy ☐ LDCT | ☐ Influenza Vax ☐ Tdap ☐ HPV rx

Physician/NP signature: _____ Date: _____