Women's Wellness Exam

Name: _____ Date of birth: _____ dd / mm / yyyy

Contact information: _____ Date of assessment: _____ dd / mm / yyyy

Current medications

Allergies

Past medical history

Family history (e.g., cancer, cardiovascular, osteoporosis)

Menstrual history

Obstetric history (e.g., pregnancies, births, complications)

Diet

Exercise

Tobacco use: _____ Alcohol use: _____

Substance use: _____

Mental health screening

Does the patient exhibit anxiety/depression symptoms?

◯ Yes ◯ No

If yes, specify: _____

Does the patient need a referral?

◯ Yes ◯ No

Blood pressure: _____ **Heart rate:** _____

Temperature: _____ **Respiration rate:** _____

Height: _____ **Weight:** _____

BMI: _____

General appearance

Heart and lung assessment

Abdomen and reflexes

Additional findings

Palpation for masses or tenderness

◯ Normal ◯ Abnormal

Skin or nipple changes

◯ Present ◯ Not present

Patient educated on self-exams

◯ Yes ◯ No

External genitalia assessment

◯ Normal ◯ Abnormal

Speculum exam (vaginal walls, cervix)

◯ Normal ◯ Abnormal

Bimanual exam (uterus, ovaries)

◯ Normal ◯ Abnormal

Notable findings

Pap performed today?

◯ Yes ◯ No

Previous pap date/result

HPV co-testing

◯ Yes ◯ No

Indication

◯ Routine ◯ Follow-up ◯ High-risk

Specimen sent to lab

◯ Yes ◯ No

HPV vaccine

◯ Up-to-date ◯ Due ◯ Not applicable

STI screening

◯ Ordered ◯ Not indicated

Mammogram

◯ Up-to-date ◯ Due ◯ Not applicable

Bone density (DEXA)

◯ Up-to-date ◯ Due ◯ Not applicable

Colorectal screening

◯ Up-to-date ◯ Due ◯ Not applicable

Other screening tests

Birth control/family planning discussed

◯ Yes ◯ No

Menopause/perimenopause management

◯ Yes ◯ No

Lifestyle and wellness counseling

☐ Diet

☐ Exercise

☐ Smoking cessation

Mental health support/referrals provided

◯ Yes ◯ No

Follow-up plan and next steps

Additional notes

Healthcare professional name: _____ **License ID number:** _____

Signature

Date of assessment: _____ dd / mm / yyyy