HEALING IN HIS WINGS, INC.

Patient's Name _____ **Date of Birth** _____ **Medical Record #** _____

WELL-WOMAN EXAM:

To help your doctor during today's health exam, **please complete items 1 through 12 and patient section on Page3.**

1. Age: _____
   First day of last menstrual period _____
   If menopausal state date _____

2. Number of times pregnant: _____
   Number of completed pregnancies: _____
   Date of last pregnancy: _____
   If you are under 50, 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 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?:
   a. Abnormal Pap smears ☐YES ☐NO
      If, yes, date _____ problem: _____
      For abnormality, did 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. Problem with present method birth control ☐YES ☐NO
   b. Bleeding between periods or since period 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 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 of 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 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: _____

7. Osteoporosis (thin) bone screening:
   a. Is there a history of any relatives with following: stooping over or losing height as they got older, "thin bones," hip fractures ☐YES ☐NO
      If yes, relation: _____

continued☞

b. Have you had any of the following:

Height loss	☐YES	☐NO
Broken hip or wrist	☐YES	☐NO
Bone-dentistry 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 6months ☐ 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 about your drinking? ☐YES ☐NO
   c. Have you ever felt guilty about your drinking? ☐YES ☐NO
   d. Have you ever had a drink thing in the morning to steady your nerves or get rid of hangover? ☐YES ☐NO

10. Prevention:
   a. Which of the following are included in your diet:

Grains and starches	☐ a lot	☐ some	☐few
Vegetables	☐ a lot	☐ some	☐few
Diary foods	☐ a lot	☐ some	☐few
Meats	☐ a lot	☐ some	☐few
Sweets	☐ a lot	☐ some	☐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 has your cholesterol level checked in the past five years? ☐ N/A ☐YES ☐NO
   e. Have you had a tetanus shot in the past ten years ☐YES ☐NO
   f. Does your house have a 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: _____ problems: _____
   For abnormality, did you have any of the following:

Biopsy	☐YES	☐NO
Cyst fluid drained	☐YES	☐NO
Surgery	☐YES	☐NO

   i. How many sexual partners have you had in the last 12 months? ____In a lifetime? ___
   j. When is the last time you had a dental check-up? _____

11. Please describe any concerns you have:

_____
_____
_____
_____
_____
_____
_____
_____
_____

12. Please list all medications (over-the counter and prescribed, dosage, strength, and daily amounts)

_____
_____
_____
_____
_____
_____
_____
_____
_____

Thank you for your help

WELL-WOMAN EXAM

PATIENT'S NAME: _____

Patient's Section

Please answer the following questions. This will help your provider identify possible problems:

When was your last PAP test ☐1 yr ☐2yrs ☐>3yrs
Were the results normal? ☐ YES ☐NO
Have you ever has an abnormal PAP test? ☐ YES ☐NO
How often do you usually get your period? Every __days
Are your periods usually regular? ☐ YES ☐NO
How many days do your period usually last? _____days
The blood flow is ☐light ☐Moderate ☐Heavy
Do you have bleeding between periods? ☐ 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? Method: _____ ☐ YES ☐ NO
Do you use condoms? ☐ Always ☐Sometimes ☐Never
Have you ever had a sexually transmitted disease? Type/Types _____ ☐ YES ☐NO?
Have your mother ever been exposed to DES☐ YES ☐NO
Have you ever use fertility medicines? ☐ YES ☐NO
Do you have hot flashes? ☐ YES ☐NO
Are you on hormone replacement? ☐YES ☐NO
Do you smoke? ☐ YES ☐NO
How often do you perform self breast-exams?
☐ Less often than monthly ☐Monthly
Do you have a history of breast problems? ☐ YES ☐NO
Have you ever been abused? ☐ YES ☐NO
Do you feel safe? ☐ YES ☐NO
Is there any family history of:

Breast cancer?	☐ YES ☐NO
Colon cancer?	☐ YES ☐NO
Uterine cancer?	☐ YES ☐NO
Ovarian cancer?	☐ YES ☐NO
Other cancers?	☐ YES ☐NO
Osteoporosis?	☐ YES ☐NO
Heart disease?	☐YES ☐NO

Do you have any allergies? ☐YES ☐NO (list **them b**elow)
Allergies: _____,_____
On a scale of 0 to 10, with 0 being no symptoms and 10 Being severe symptoms, 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 tension syndrome):
0 1 2 3 4 5 6 7 8 9 10
If you have been pregnant please indicate how many
Pregnancies____ Abortions ___ Living children _____
Full-term live births _____ Premature births _____

Please list any other concerns: _____
_____
_____
_____

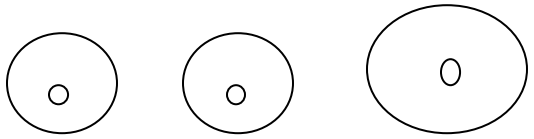
Provider's Section:

Abnormal findings should be described below or on the reverse side of this form. For VS and allergies, see separate note on chart.

Nl	Abn.		Nl	Abn.	
☐	☐	HEENT	☐	☐	ABDOMEN
☐	☐	THROID	☐	☐	SKIN
☐	☐	LUNGS	☐	☐	EXTREMITES
☐	☐	HEART	☐	☐	NEURO

If there are any abnormalities, circle the specific one(s) and describe below or on reverse.

Nl	Abn.	
☐	☐	**BREAST** Masses Lump Tenderness Symmetry Nipple discharge Axilla
☐	☐	**EXTERNAL GENITALIA** Appearance Hair distribution Lesions
☐	☐	**URETHRA & MEATUS** Size Location Lesions Prolapse Masses Tenderness Scarring
☐	☐	**VAGINA** Appearance Estrogen effect for age/meds Discharge Lesions Pelvic support Cystocele Rectocele
☐	☐	**CERVIX** Appearance Lesions Discharge
☐	☐	**UTERUS** Size Contour Position Mobility
☐	☐	**ADNEXA** Masses Tenderness Organomegaly Nodularity
☐	☐	**BLADDER** Fullness Masses Tenderness
☐	☐	**ANUS & PERINEUM**
☐	☐	**RECTAL** Tone Hemorrhoids Masses
☐	☐	**HEMOCCULT**
☐	☐	**KOH/WET PREP**
☐	☐	**ACETIC ACID WASH**



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