Patient Name: ___________________________ Date Birth: ___________________ Age: _____________

GCH Clinics - Well Female Exam

Please complete before your appointment for a physical

History: (Please answer the following)

Number of pregnancies ________ Number of births ________ Date of last pregnancy _________ Birth Control Used _______

Last Menstrual period _____________ If through Menopause, do you take Calcium, Estrogen, or Progesterone ____________

Are you having any problems with – (Please circle either yes or no)

Skin changes	Yes	No		Abdominal pains	Yes	No		Feeling depressed	Yes	No
Changes in mole	Yes	No		Constipation	Yes	No		Birth control options	Yes	No
Severe headaches	Yes	No		Diarrhea	Yes	No		Bleeding between periods	Yes	No
Vision problems	Yes	No		Changes in stools	Yes	No		Pain with intercourse	Yes	No
Joint pains	Yes	No		Blood in stools	Yes	No		Little interest in intercourse	Yes	No
Chest pains	Yes	No		Nausea / Vomiting	Yes	No		Lump in breasts	Yes	No
Shortness of breath	Yes	No		Fatigue	Yes	No		Other Concerns:		
Heartburn	Yes	No		Sleeping poorly	Yes	No				
Back pains	Yes	No		Numbness/ Weakness	Yes	No				
Hearing	Yes	No		Appetite	Yes	No				

Have you had any of the following - (Please circle either yes or no)

Heart disease	Yes	No		Cancer	Yes	No		Special pelvic tests / procedures	Yes	No
High Cholesterol	Yes	No		Abnormal pap smears	Yes	No		Height loss	Yes	No
High blood pressure	Yes	No		Pelvic surgery	Yes	No		Broken hip or wrist	Yes	No

Previous Surgeries: (Please List) ____

(Examples include: Tonsils, Back, Hernia, Appendix, Gall Bladder, Cervix, Colon, etc.)

Medications: (include non-prescription)

Name of Medication	Strength	How Often		Name of Medication	Strength	How Often

Routine Screenings / Testing : (Please indicate the year in which you last had the following and any abnormalities)

Tetanus Shot ___________ Flu Shot ___________ Pneumonia Shot ________ Zostavax (shingles) Shot _______

HPV Shot __________ Cholesterol Lab Screening: _______ Hepatitis C Lab Screening: __________

Eye Exam ___________ Dental Exam ___________ Bone Density (DEXA) _______

Pap Smear __________ Colonoscopy __________ Mammogram ______________

Social History:

Marital Status: Single Married Separated Divorced Widowed

Use of Alcohol: Never Rarely Moderate Daily Drinks per day: __________

Use of Tobacco: Never Previously, but quit Current Packs per day: ___________

Use of Drugs: Never Current Type / Frequency ___________

Caffeine: Never Current – type/frequency per day ______

Exercise: Never Current – type / frequency per week _______

Do you have a Living Will or Advance Directives: Yes No

Family Medical History:

	Age	Diseases	If Deceased, Age and Cause of Death
Father	______________	____________________________	__________________________________
Mother	______________	____________________________	__________________________________
Siblings	______________	____________________________	__________________________________
Children	______________	____________________________	__________________________________