WELL FEMALE EXAM

1. **GYN:** Are your "cycles" regular? . . . . . **YES NO**
   Do you have painful periods? . . . . . **YES NO**
   Do you do self breast exams? . . . . . **YES NO**
   Have you had a Hysterectomy? . . . . . **YES NO**
   (If so, were ovaries removed? . . . . . **YES NO**
   Do you have night sweats? . . . . . **YES NO**
2. **GENERAL:** Do you have
   A. Change in appearance of a mole or a rash anywhere? . . . . . **YES NO**
   B. Significant headaches? **YES NO** (If so, how many caffeine drinks do you average per day? __) . . . . . **YES NO**
   C. Often feeling down, depressed or hopeless during the past month? . . . . . **YES NO**
   D. Often having little interest or pleasure in doing things in the past month? . . . . . **YES NO**
   E. Change in size/firmness of stools? **YES NO** Heartburn or does food get caught in your throat? . . . . . **YES NO**
   F. Leak urine? (If so, is it when you cough and/or sneeze? . . . . . **YES NO**
   G. Get up to urinate more than once a night? . . . . . **YES NO**
   H. Trouble falling or staying asleep? . . . . . **YES NO**
   I. Do you snore loudly? . . . . . **YES NO**
   J. If you have sleep apnea, do you use your CPAP nightly? . . . . . **YES NO**
   K. Allergies or hay-fever? . . . . . **YES NO**
   L. If 60 years old and older - Do you have a living will? . . . . . **YES NO**
   M. Pain? Where? _____ For how long? _____ How sever? (on a 1-10 scale) _____

3. Have any of your close relatives had: Cancer of breast, colon or female organs? . . . . . **YES NO**
   Heart attacks before age 55? . . . . . **YES NO**

4. **Tobacco:** I quit ____ years ago. I last tried to quit ____ years ago. ____ I have no interest in quitting. . . . . **YES NO**
   Have you ever tried Chantix? . . . . . **YES NO**

5. **Do you drink alcohol?** Average drinks per week? ____ - ____ . . . . . **YES NO**
   If yes, A. Have you ever felt like you should cut down on your drinking? . . . . . **YES NO**
   B. Do people annoy you by nagging you about your drinking? . . . . . **YES NO**
   C. Have you ever felt guilty about your drinking? . . . . . **YES NO**
   d. Have you drank in the morning to steady your nerves? . . . . . **YES NO**

6. How many days a week do you do cardiovascular exercise? ____ Level of exertion? **Stroll Mild Heavy**
7. **Vaccines**: Please circle - **Tetanus** (within past 10 years) **Pneumococcal** (if 65 years and older) **Singles** (if 65 years and older) **Flu**
8. **Colon Cancer Screening**: Colonoscopy or Stool Cards? **YES NO** When? __ _ Year(s) ago. Who did it? _____
9. Breast Cancer Screening/Mammogram: How long ago? _____
10. Have you had a bone density test? **YES NO** If so, when and where? _____
11. When was the last time you had a dental check-up? _____ Eye Exam? _____

What over-the-counter medications do you take? _____

_____

Please circle if you take **Calcium & Vitamin D Estrogen Evista Progesterone (Provera) Aspirin 81 or 325 mg**

Please describe any health concerns you have. _____

_____

Any specific prayer requests? _____

Reviewed with patient (Stewart Tankersley, M.D.) _____ Date (same as visit) ____/____/_____

Please Complete NAME: _____ AGE: _____ DATE: ____/____/_____