FLINT
FAMILY HEALTHCARE
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# Well Checkup - Female: 18 and up

Patient Name:

_____DOB:_____Appt. Date: _____

Please answer each question below.

| | |
|---|---|
| When was your last breast exam by a medical provider?<br>☐ Unsure<br>☐ Date: _____ | When was your last mammogram?<br>☐ Unsure<br>☐ Date: _____ |
| When was your last pap smear?<br>☐ Unsure<br>☐ Date: _____ | When was your last physical?<br>☐ Unsure<br>☐ Date: _____ |
| When was your last vision exam?<br>☐ Unsure<br>☐ Date: _____ | When was your last dental exam?<br>☐ Unsure<br>☐ Date: _____ |
| When was your last tetanus shot?<br>☐ Unsure<br>☐ Date: _____ | When was your last bone density test?<br>☐ Unsure<br>☐ Date: _____ |
| When was your last colonoscopy?<br>☐ Unsure<br>☐ Date: _____ | Have you had any pelvic pain?<br>☐ Yes<br>☐ No |
| List providers you have seen since your last visit<br><br>. | Any current health concerns? |
| Would you like a flu shot today?<br>☐ Yes<br>☐ No | |
| Would you like any STD testing to be completed today?<br>☐ Yes<br>☐ No | |

| | | |
|---|---|---|
| Have you had any breast symptoms, including… | Lumps<br>Pain<br>Nipple Discharge | Yes or No<br>Yes or No<br>Yes or No |
| Have you had vaginal symptoms? | Abnormal Vaginal Discharge<br>Vaginal Itch<br>Vaginal Odor<br>Vaginal Dryness | Yes or No<br>Yes or No<br>Yes or No<br>Yes or No |
| Have you had any menstrual irregularities? | Missing Periods<br>Bleeding Between Periods<br>Pain with Periods | Yes or No<br>Yes or No<br>Yes or No |
| Have you had any sexual dysfunction? | Pain with Intercourse<br>High Sex Drive<br>Low Sex Drive | Yes or No<br>Yes or No<br>Yes or No |
| Have you had any of the following? | Hot flashes<br>Night Sweats<br>Difficulty Sleeping<br>Mood Swings<br>Irritability<br>Sadness<br>Depression | Yes or No<br>Yes or No<br>Yes or No<br>Yes or No<br>Yes or No<br>Yes or No<br>Yes or No |
| Have you had any of the following urinary symptoms? | Pain Urinating<br>Burning with Urination<br>Frequent Urination<br>Increased Urgency to Urinate<br>Non-Menstrual Blood in Urine<br>Unwanted Leakage of Urine | Yes or No<br>Yes or No<br>Yes or No<br>Yes or No<br>Yes or No<br>Yes or No |
| Have you been diagnosed with any of the following breast disorders? | Fibrocystic Breast Disease<br>Breast Cysts<br>Breast Cancer | Yes or No<br>Yes or No<br>Yes or No |
| Have you been diagnosed with any of the following gynecological disorders? | Ovarian Cysts<br>Polycystic Ovarian Syndrome<br>Endometriosis<br>Uterine Fibrosis<br>Pelvic Organ Prolapse | Yes or No<br>Yes or No<br>Yes or No<br>Yes or No<br>Yes or No |
| Have you had any of the following procedures completed? | Breast Cyst Aspiration<br>Breast Biopsy<br>Ovarian Cyst Aspiration<br>Vulvar Biopsy<br>Colposcopy<br>Endometrial Biopsy<br>D & C<br>Laparoscopy<br>Hysterectomy | Yes or No<br>Yes or No<br>Yes or No<br>Yes or No<br>Yes or No<br>Yes or No<br>Yes or No<br>Yes or No<br>Yes or No |

| | | |
|---|---|---|
| Have you ever been diagnosed with osteoporosis?<br>☐ Yes<br>☐ No | When was your last bone scan?<br>☐ Unsure<br>☐ Never<br>☐ Date: _____ | What are your plans for pregnancy? |
| Are you having trouble with your current contraceptive method?<br>☐ Yes<br>☐ No | Have you had any trouble trying to get pregnant?<br>☐ Yes<br>☐ No | Have you been exposed to DES?<br>☐ Yes<br>☐ No |
| Does your family have any history of breast cancer?<br>☐ Yes<br>☐ No | Do you have a family history of osteoporosis?<br>☐ Yes<br>☐ No | |

# *Female Health Assessment*

Which of the following symptoms apply to you currently (in the last 2 weeks)? Please mark the appropriate box for each symptom. For symptoms that do not currently apply or no longer apply, mark "none."

| Symptoms | None (0) | Mild (1) | Moderate (2) | Severe (3) | Very Severe (4) |
|---|---|---|---|---|---|
| Hot flashes | ☐ | ☐ | ☐ | ☐ | ☐ |
| Sweating (night sweats or increased episodes of sweating) | ☐ | ☐ | ☐ | ☐ | ☐ |
| Sleep problems (difficulty falling asleep, sleeping through the night, or waking up too early) | ☐ | ☐ | ☐ | ☐ | ☐ |
| Depressive mood (feeling down, sad, on the verge of tears, lack of drive) | ☐ | ☐ | ☐ | ☐ | ☐ |
| Irritability (mood swings, feeling aggressive, and getting angry easily). | ☐ | ☐ | ☐ | ☐ | ☐ |
| Anxiety (inner restlessness, feeling panicky, feeling nervous, inner tension) | ☐ | ☐ | ☐ | ☐ | ☐ |
| Physical exhaustion (general decrease in muscle strength or endurance, decrease in work performance, fatigue, lack of energy, stamina, or motivation) | ☐ | ☐ | ☐ | ☐ | ☐ |
| Sexual problems (change in sexual desire, sexual activity, orgasm, and/or satisfaction) | ☐ | ☐ | ☐ | ☐ | ☐ |
| Bladder problems (difficulty in urinating, increased need to urinate, incontinence) | ☐ | ☐ | ☐ | ☐ | ☐ |
| Vaginal symptoms (sensation of dryness or burning in the vagina, difficulty with sexual intercourse) | ☐ | ☐ | ☐ | ☐ | ☐ |
| Joint and muscular symptoms (joint pain or swelling, muscle weakness, poor recovery after exercise) | ☐ | ☐ | ☐ | ☐ | ☐ |
| Difficulties with memory | ☐ | ☐ | ☐ | ☐ | ☐ |
| Problems with thinking, concentrating, or reasoning | ☐ | ☐ | ☐ | ☐ | ☐ |
| Difficulty learning new things | ☐ | ☐ | ☐ | ☐ | ☐ |
| Trouble thinking of the right word to describe persons, places, or things when speaking | ☐ | ☐ | ☐ | ☐ | ☐ |
| Increase in frequency or intensity of headaches or migraines | ☐ | ☐ | ☐ | ☐ | ☐ |
| Hair loss, thinning, or a change in the texture of hair | ☐ | ☐ | ☐ | ☐ | |
| Feel cold all the time or have cold hands or feet | ☐ | ☐ | ☐ | ☐ | ☐ |
| Weight gain or difficulty losing weight despite diet and exercise | ☐ | ☐ | ☐ | ☐ | ☐ |
| Dry or wrinkled skin | ☐ | ☐ | ☐ | ☐ | ☐ |
| Total Score: | | | | | |

Severity Score: Mild: 1-20 / Moderate: 21-40 / Severe: 40-60 / Very severe: 61-80