THE SHOULDER
INTAKE EXAM

WOMENS CENTER
MOBILE

WELL WOMAN EXAM FORM

_____Initial Exam

_____Annual

Name_____ _____
Last First Middle

Date of Birth_____Marital Status: S M W D

Address_____Telephone_____
Street City State Zip Code

Next of Kin_____Telephone_____
Name Relationship

Family Physician_____Telephone_____

FAMILY MEDICAL HISTORY

	Age	State of Health	if deceased, cause	age at death
Father				
Mother				
Brother(s)				
Sister(s)				

SMOKING:

Do you smoke?_____

If yes, # per day_____

Never smoked_____

Stopped (date)_____

Has any blood relation (parent, brother/sister) had: _____Asthma/hay fever_____Cancer_____Diabetes

_____Heart Trouble/Stroke, Clots_____High Blood Pressure_____Kidney trouble_____Thyroid Disease_____Tuberculosis

PERSONAL MEDICAL HISTORY: Have you ever had or do you have now: (please check at left of each item)

___Abnormal Pap Smear	___Dysentery	___Hodgkin's disease	___Pneumonia
___Alcohol/Drug Use	___Eating Disorder	___Infectious Mononucleosis	___Rectal Trouble
___Anemia	___Encephalitis	___Jaundice	___Rheumatic fever
___Asthma/Hay fever	___Epilepsy	___Kidney trouble	___Rubella
___Bleeding disorders	___Frequent headaches	___Liver disease	___Scarlet fever
___Bloody urine	___Gallbladder disease	___Malaria	___Sinusitis
___Cancer/Leukemia	___Goiter/Thyroid treatment	___Measles	___STD/STI
___Chicken Pox	___Heart murmur	___Meningitis	___Strep throat
___Chronic cough	___Heart trouble	___Migraine headaches	___Tuberculosis
___Convulsions	___Hepatitis B	___Pain in chest	
___Diabetes	___High blood pressure	___Pleurisy	

Serious illnesses or hospitalizations (list)_____

Surgeries or injuries (broken bones, head injury, etc.)_____

Allergy to drugs, food, plants, other_____

Current medications_____

Age menstrual periods began_____Date of last menstrual period_____Number of days from period to next_____

Days of flow_____Heavy_____Medium_____Light_____Pain with periods _____Abnormal periods_____

Age at first intercourse_____Number of pregnancies_____Number of deliveries_____Any abortions_____

Type of contraceptive_____Number of partners in last 6 months_____How long with present partner_____

Date of last Pap Smear_____Any Abnormal Pap Smears_____Type of treatment_____

Physical Examination . Name_____

Blood Pressure_____Pulse_____Weight_____Height_____LMP_____

Normal	Abnormal	Check appropriately and describe abnormalities.
_____	_____	Head, Scalp and Face_____
_____	_____	Eyes_____Date of Last Exam_____
_____	_____	Vision:_____with glasses_____without glasses_____
_____	_____	Right:_____ | _____
_____	_____	Left:_____ | _____
_____	_____	Color Vision:_____ | _____
_____	_____	Ears_____
_____	_____	Nose_____
_____	_____	Mouth and throat_____
_____	_____	Teeth_____Last Exam:_____
_____	_____	Neck_____
_____	_____	Lungs_____
_____	_____	Heart_____
_____	_____	Breasts_____
_____	_____	Abdomen_____
_____	_____	Rectal_____
_____	_____	Hernia_____
_____	_____	Adenopathy_____
_____	_____	Musculo-skeletal_____
_____	_____	Neurological_____
_____	_____	Skin_____
_____	_____	Femoral and pedal pulses_____
_____	_____	PELVIC:
_____	_____	Ext. Gent and Bus_____
_____	_____	Vagina_____
_____	_____	Cervix_____
_____	_____	Uterus_____AF_____M_____RF_____
_____	_____	Adnexa_____
_____	_____	Recto-Vag_____

Labwork: _____Pap Smear_____GC_____Chlamydia_____UA_____CBC

_____Rubella Titer_____RPR_____Other:_____

Date of last Tetanus (Td) vaccine:_____

Summary of s health:

a. Physical:_____

b. Mental:_____

c. Recommendations for follow up:_____

d. Immunizations reviewed_____copies made_____copied to Immunization record_____

Date of Exam_____Examined by:_____

Signature of Physician/APRN/PA_____Degree_____

Address_____