

Female Annual Physical Exam

Personal Information:

- Name:
- Date of Birth:
- Date of Exam:
- Healthcare Provider:
- Next Appointment:

Medical History Update:

- Current health issues:
- New diagnoses or hospitalizations:
- Recent surgeries or procedures:
- Current medications and doses:
- Allergies (medication/food/others):
- Family medical history changes:

Vital Signs:

- Blood Pressure:
- Heart Rate:
- Respiration Rate:
- Temperature:
- Weight:
- Height:
- Body Mass Index (BMI):

Physical Examination:

- General Appearance:
 - Normal
 - Abnormal
- Heart Exam:
- Lung Exam:
- Abdominal Exam:

- Skin Exam:
- Head and Neck Exam:
- Neurological Exam:
- Musculoskeletal Exam:

Breast and Pelvic Exam:

- Breast Exam:
 - Normal
 - Abnormal Findings
- Self-Breast Exam Instructions Received:
 - Yes
 - No
- Pelvic Exam:
 - Scheduled
 - Completed
- Pap Smear:
 - Scheduled
 - Completed
 - Results: _____
- HPV Test:
 - Scheduled
 - Completed
 - Results: _____

Laboratory Tests and Screenings:

- Blood Glucose:
- Cholesterol Profile:
- Thyroid Function Test:
- Liver Function Tests:
- Kidney Function Tests:
- Hemoglobin/Hematocrit:

- Vitamin D Level:
- STI Screening:
 - Needed
 - Completed
- Other tests as recommended: _____

Immunizations:

- Flu Vaccine:
 - Received
 - Scheduled
- Tetanus/Diphtheria/Pertussis (Tdap):
 - Up-to-Date
 - Scheduled
- Human Papillomavirus (HPV):
 - Up-to-Date
 - Scheduled
- Others: _____

Cancer Screenings:

- Mammogram:
 - Scheduled
 - Completed
 - Results: _____
- Colonoscopy:
 - Scheduled
 - Completed
 - Results: _____
- Lung Cancer Screening (if applicable):
 - Scheduled
 - Completed
 - Results: _____

- Skin Cancer Screening:

- Scheduled
- Completed
- Results: _____

Bone Density Screening:

- DEXA Scan:

- Scheduled
- Completed
- Results: _____

Vision and Hearing:

- Vision Test:

- Scheduled
- Completed
- Results: _____

- Hearing Test:

- Scheduled
- Completed
- Results: _____

Lifestyle and Mental Health:

- Nutrition and Diet Consultation:

- Needed
- Completed

- Physical Activity: _____

- Smoking Status:

- Never
- Former
- Current

- Alcohol Use:

- Drug Use:

• **Mental Health Screening:**

- Needed
- Completed

• **Stress Level:**

- Low
- Moderate
- High

• **Sleep Quality:**

- Good
- Fair
- Poor

Menopausal Symptoms and Management:

1. Menopause Status:

- Pre
- Peri
- Post

2. Symptoms: _____

3. Treatment/Management: _____

Notes and Recommendations:

Signatures:

- Patient: _____
- Healthcare Provider: _____
- Date: _____