

# Women's Wellness Exam Checklist

## Patient Information

Full Name: \_\_\_\_\_

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

Contact Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

## Health History Review

- Current medications and supplements: \_\_\_\_\_
- Past surgeries or hospitalizations: \_\_\_\_\_
- Family medical history: \_\_\_\_\_
- Personal medical history: \_\_\_\_\_
- Allergies (medications, food, environmental): \_\_\_\_\_
- Immunization status: \_\_\_\_\_

## Vital Signs Check

- Blood pressure: \_\_\_\_\_
- Heart rate: \_\_\_\_\_
- Respiratory rate: \_\_\_\_\_
- Temperature: \_\_\_\_\_
- Weight: \_\_\_\_\_
- Height: \_\_\_\_\_

## General Physical Exam

- Head and neck exam: \_\_\_\_\_
- Thyroid check: \_\_\_\_\_
- Lung auscultation: \_\_\_\_\_
- Heart auscultation: \_\_\_\_\_
- Abdominal exam: \_\_\_\_\_

Skin check: \_\_\_\_\_

### **Women's Health Specifics**

Breast exam: \_\_\_\_\_

Pelvic exam: \_\_\_\_\_

Pap smear (if due): \_\_\_\_\_

Human Papillomavirus (HPV) testing (if due): \_\_\_\_\_

Sexual health discussion: \_\_\_\_\_

Contraception counseling: \_\_\_\_\_

Menstrual cycle review: \_\_\_\_\_

Menopause management (if applicable): \_\_\_\_\_

### **Screenings and Tests**

Cholesterol screening: \_\_\_\_\_

Diabetes screening: \_\_\_\_\_

Bone density scan (if applicable): \_\_\_\_\_

Mammogram (if due): \_\_\_\_\_

Colon cancer screening (if due): \_\_\_\_\_

STI screenings (as indicated): \_\_\_\_\_

### **Lifestyle and Wellness**

Nutrition and diet review: \_\_\_\_\_

Physical activity assessment: \_\_\_\_\_

Mental health screening: \_\_\_\_\_

Sleep quality assessment: \_\_\_\_\_

Tobacco, alcohol, and substance use assessment: \_\_\_\_\_

Stress management discussion: \_\_\_\_\_

### Preventive Health Counseling

Vaccinations update: \_\_\_\_\_

Cancer prevention tips: \_\_\_\_\_

Heart health recommendations: \_\_\_\_\_

Osteoporosis prevention (if applicable): \_\_\_\_\_

### Patient Questions and Concerns

List any specific concerns or symptoms: \_\_\_\_\_

List any questions for the healthcare provider: \_\_\_\_\_

### Plan and Recommendations

Follow-up appointment scheduling: \_\_\_\_\_

Referrals to specialists (if needed): \_\_\_\_\_

Prescriptions or medication adjustments: \_\_\_\_\_

Recommended lifestyle modifications: \_\_\_\_\_

Educational materials or resources provided: \_\_\_\_\_

**Healthcare Provider's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

### Patient Acknowledgment

- I have discussed the above items with my healthcare provider and understand the recommendations provided.

**Patient's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_