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: ____ / ____ / ________