

Women's Wellness Exam

Patient Information

- Name: _____
- Date of Birth: _____
- Home Address: _____
- Phone: _____
- Emergency Contact: _____

Medical History

- Current Medications: _____
- Allergies: _____
- Past Surgeries: _____
- Chronic Conditions: _____

Reproductive Health

- **Menstrual History**
 - Age of Menarche: _____
 - Regularity of Menstrual Cycles: _____
- **Contraceptive History**
 - Current Contraceptive Method: _____
 - Satisfaction and Side Effects: _____

Lifestyle Factors

- Dietary Habits: _____
- Physical Activity: _____
- Substance Use: _____

Physical Examination

- **Vital Signs**
 - Blood Pressure: _____
 - Heart Rate: _____

- Respiratory Rate: _____
- Body Mass Index (BMI): _____
- **Breast Examination:**

- **Pelvic Examination:**

Screenings

- **Mammogram:**

- **Bone Density Test:**

- **Cervical Cancer Screening:**

- **Cholesterol Levels:** _____

Mental Health

- **Stress Levels:**

- **Mood and Emotional Well-being:**

Education and Counseling

- **Preventive Measures:**

- **Family Planning:**

- **Follow-Up Recommendations:**