Women's Wellness Exam

Date of assessment: _____

Patient information	
Name:	Date of birth:
Contact information:	
Medical history review	
Current medications:	**Allergies:**
Past medical history:	**Menstrual history:**
Family history (e.g., cancer, cardiovascular, osteoporosis):	**Obstetric history (e.g., pregnancies, births, complications):**
Lifestyle habits:	
Diet:	Exercise:
Tobacco use:	Alcohol use:
Substance use:	

Mental health screening:

Anxiety/depression symptoms:	Yes	No
If yes, specify:		
Referral needed:	Yes	No

Physical examination

Vital signs:

Blood pressure:	Heart rate:
Temperature:	Respiration rate:
Height:	Weight:
BMI:	

General appearance:	**Heart and lung assessment:**

Abdomen and reflexes:	**Additional findings:**

Breast exam

Palpation for masses or tenderness:	Normal	Abnormal
Skin or nipple changes:	Present	Not present
Patient educated on self-exams:	Yes	No

Pelvic exam

External genitalia assessment:	Normal	Abnormal
Speculum exam (vaginal walls, cervix):	Normal	Abnormal
Bimanual exam (uterus, ovaries):	Normal	Abnormal

Notable findings:

Pap smear

Pap performed today?	Yes	No

Previous pap date/result:

HPV co-testing:	Yes	No

Indication:		
Routine	Follow-up	High-risk

Specimen sent to lab:	Yes	No

Vaccinations and preventive screenings

HPV vaccine:		
Up-to-date	Due	Not applicable

STI screening:	Ordered	Not indicated

Mammogram:		
Up-to-date	Due	Not applicable

Bone density (DEXA):		
Up-to-date	Due	Not applicable

Colorectal screening:		
Up-to-date	Due	Not applicable

Other screening tests:

Counseling and education

Birth control/family planning discussed:	Yes	No
Menopause/perimenopause management:	Yes	No

Lifestyle and wellness counseling:

Diet	Exercise	Smoking cessation

Mental health support/referrals provided:	Yes	No

Follow-up plan and next steps:

Additional notes

Healthcare professional information

Name:	License ID number:
Signature:	Date of assessment: