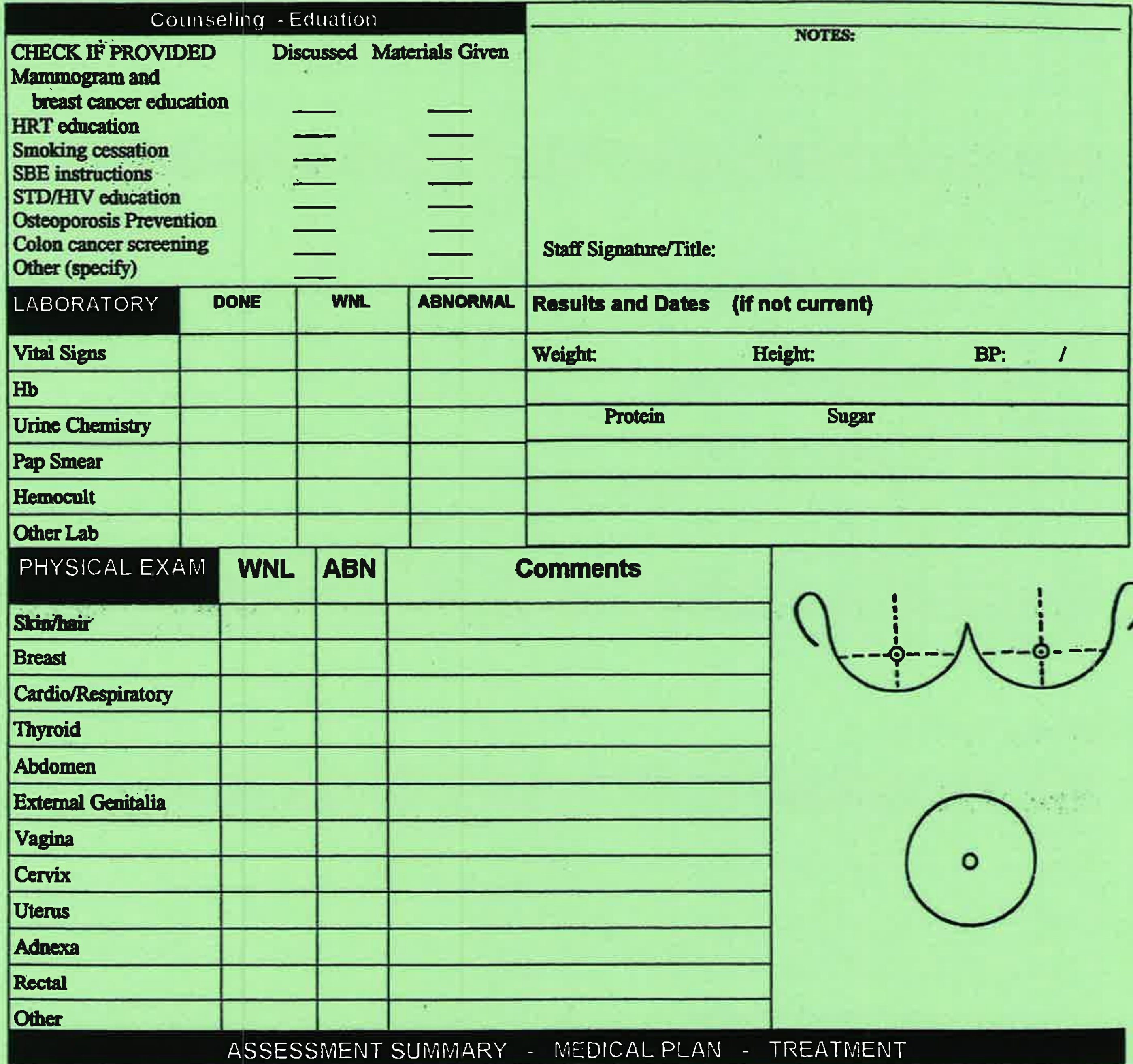
ANNUAL MEDICAL EXAM RECORD FOR WOMEN 50 YEARS AND OLDER

Date of Visit	Patient Name	Age



Counseling - Eduation		
CHECK IF PROVIDED	Discussed	Materials Given
Mammogram and breast cancer education	____	____
HRT education	____	____
Smoking cessation	____	____
SBE instructions	____	____
STD/HIV education	____	____
Osteoporosis Prevention	____	____
Colon cancer screening	____	____
Other (specify)	____	____

NOTES:

Staff Signature/Title:

LABORATORY	DONE	WNL	ABNORMAL	Results and Dates (if not current)
Vital Signs				Weight: Height: BP: /
Hb				
Urine Chemistry				Protein Sugar
Pap Smear				
Hemocult				
Other Lab				

PHYSICAL EXAM	WNL	ABN	Comments
Skin/hair			
Breast			
Cardio/Respiratory			
Thyroid			
Abdomen			
External Genitalia			
Vagina			
Cervix			
Uterus			
Adnexa			
Rectal			
Other			

ASSESSMENT SUMMARY - MEDICAL PLAN - TREATMENT

Return Visit: ____________ Clinician Signature/Title: ______________________ Date: __________

SKU 10/03

Patient Name________________________________ Birth Date______________ Age____ Patient Number______________

MEDICAL HISTORY	YES	NO
A. Have you seen a doctor since your last visit with us? If so, for what and when?		
B. Has any family member had a serious illness or death this past year? If so, who and what?		
C. Any surgeries or hospitalizations this year? What and when?		
D. List any conditions that you are presently being treated for:		

CURRENT MEDICAL PROBLEMS	YES	NO
A. Breast problems?		
B. Problems with urination?		
C. Abnormal weight gain or loss in last year?		
D. Problems with abdominal/stomach pain/rectal bleeding?		
E. Current problems with depression?		
F. Chest pain, shortness of breath, swelling in legs?		
G. Severe headaches?		
H. Any concerns about physical or sexual abuse?		
I. Do you smoke? If yes,________________ packs per day		
J. Do you drink alcohol? If yes, what____________________ amount per week?		
K. Do you use "street" drugs? If yes, what______________________ how much/week?		

MEDICATIONS

List all medications you are taking now. (Include viatmins, prescription drugs, and over-the-counter medication)

Allergies to Medications ☐ **NKA**

GYNECOLOGICAL HISTORY	YES	NO
A. Are you still having periods? _____yes _____no If yes, any problems with your period?		
B. If you are post menopausal, have you had any bleeding this year?		
C. Are you having sex? _____yes _____no If yes, any pain or problems?		
D. Do you need birth control today or hormone replacement therapy?		
E. Is there any family history of breast, cervical, uterine, colon or ovarian cancer?		
F. Any current vaginal discharge, odor or infections?		
G. Any questions or concerns today?		

Last pelvic exam_____/_____/_____ Number of times pregnant________ Number of births________

PATIENT SIGNATURE:______________________________________ **DATE:**______________

STAFF NOTES

Staff Signature/Title: ____ **Date**______________