Lisa P. Otey, M.D., P.A.

Female Assessment
Extended/Well Woman Exam

Patient Name: _____
DOB: _____
MR No.: _____

Date and Time: _____ PCP: _____
Age: _____ Marital Status ☐ M ☐ W ☐ D ☐ Sp ☐ S Occupation: _____
Telephone (Day) _____ (Evening) _____
Reason for Visit: _____

SECTION TO BE COMPLETED BY PATIENT:
Do you have a problem with? (Please check all applicable and explain below)

☐ Excessive Weight	☐ Eyes	☐ Breast
☐ Heart Disease	☐ Ears/Nose/Throat	☐ Mental Health
☐ High Blood Pressure	☐ Skin	☐ Glands
☐ Fever	☐ Muscle/Bone	☐ Thyroid
☐ Stomach or Bowels	☐ Lungs	☐ Blood Clots
☐ Diabetes	☐ Brain/Nerves	☐ Other

Health Maintenance (Date last done)
Bone Density: _____
Lipid Profile: _____
Mammogram: _____
Tetanus: _____
Influenza: _____
Pneumovax: _____
Flex Sigmoidoscopy: _____
Other: _____

Medical Problems: (explained from above) _____

Current Medications/Supplements: (Please List) _____

BC Method _____
Drug allergies? ☐ No ☐ Yes (Give drug and reaction, i.e. rash, nausea, etc) _____

Do you Exercise? ☐ No ☐ Yes What Kind? _____ How often? _____

Do you Smoke? ☐ No ☐ Yes How Much? _____ How Long? _____

Do you Use Alcohol? ☐ No ☐ Yes How Much? _____ How Long? _____

Have you ever used Drugs? ☐ No ☐ Yes What Kind? _____ How often? _____ How Long? _____

Have you ever had a major illness/hospitalization/surgery? ☐ No ☐ Yes Explain: _____

Is there a family history of: (Please Check) ☐ Colon Cancer ☐ Ovarian Cancer ☐ Diabetes ☐ Breast Cancer
☐ Heart Disease ☐ High Blood Pressure Other: _____

Physician's Notes:
☐ Medical History Reviewed:
Notes: _____

Physician's Signature: _____

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Patient Name: _____
DOB: _____
MR No.: _____

AGE:	WT:	HT:	T:	BP:	P:	RR:
LMP:	G:	P: Term	Pre-term:	AB:	L:	Last Pap:	Last Mammogram

Advanced Directives: Discussed/Information Given Y/N Completed Y/N Copy on File Y/N

Nursing Staff Signature/Title ☐ CLINICAL PROFILE UPDATED

Physical Examination (✓ - Within Normal Limits or Negative Problems)

Focused		Expanded	
BREAST		General Appearance	
Masses ☐		HEENT ☐	
Skin Change ☐		NECK ☐	
Nipple Changes ☐		THYROID ☐	
Symmetry ☐		LUNGS ☐	
Tenderness ☐		HEART ☐	
PELVIC		ABDOMEN	
Vulva ☐		Masses or Tenderness ☐	
Urethra ☐		Hernias ☐	
Vagina ☐		Liver/Spleen ☐	
Cervic ☐		LYMPH ☐	
Uterus ☐		EXTREMETIES ☐	
Adnexae ☐		NEUROLOGIC ☐	
Anus/Perineum ☐		SKIN ☐	
Pap Done ☐	☐ Y ☐ N	RECTAL ☐	
GC/Chlamydia Done ☐	☐ Y ☐ N	GUALAC	☐ NEG ☐ POS
		Control	☐ Y ☐ N

☐ Health Maintenance Guidelines Reviewed

EDUCATION/TEACHING	(Check if Done)	ORDERS/LAB	(Check if Done)
☐	Smoking Cessation	☐	Hemocrit
☐	STD Prevention/Counseling	☐	Hgh/Hct
☐	Menstrual Cycle	☐	UA
☐	Contraceptive Counseling	☐	Lipid Profile
☐	Menopausal	☐	Glucose
☐	Prevention of Osteoporosis	☐	FSH
☐	Hormone Replacement Therapy	☐	Thyroid Functions
☐	Breast Self Examination	☐	Other

Screening Recommendations: ☐ Mammography ☐ Bone Density ☐ Flexi-Sigmoidoscopy

Immunization Recommendation: ☐ Td ☐ Flu ☐ Pneumovax ☐ Rubella

ACOG Pamphlets Given _____
Assessment Plan _____

_____

_____

_____

Return Appt: _____
Physician's Signature: _____ ☐ CC: to Referral Provider