TATUM HIGHLANDS MEDICAL ASSOCIATES

26224 N Tatum Blvd, Suite 15A
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P: (480) 663-9632 F: (480) 419-6782

WELL WOMAN EXAM

Patient Name: ____ **DOB:** ____________________________

Please answer the following questions. This will help your provider identify possible problems.

- When was your last mammogram? ____/_____/______
- When was your last period? _____/______/______
- When was your last PAP test? _____ 1 YR _____2 YR _______>3 YRS
- Were the results normal? _____ Yes _____ No
- Have you ever had an abnormal PAP test? _____ Yes _____ No
- How often do you usually get your period? Every_____ days
- Are your periods regular? _____ Yes _____ No
- How many days does your period last? _______ days
- The blood flow is: _____ Light _____ Moderate _____ Heavy
- Do you have any bleeding between periods? _____ Yes _____ No
- Do you have any vaginal discharge? _____ Yes _____ No
- Are you sexually active? _____ Yes _____ No
  - If yes, do you and your partner use birth control? _____ Yes _____ No
    Method:______________
- Have you ever had a sexually transmitted disease? _____ Yes _____ No
- Have you ever used fertility medicines? _____ Yes _____ No
- Do you have hot flashes? _____ Yes _____ No
- Are you on hormone replacement? _____ Yes _____ No
- Do you smoke? _____ Yes _____ No
- How often do you perform self-breast-exams?
  - _____ Less than Monthly _____ Monthly
- Do you have history of breast problems? _____ Yes _____ No
- Is there family history of:
  - Breast Cancer?_____ Yes _____ No
  - Colon cancer? _____ Yes _____ No
  - Uterine cancer? _____ Yes _____ No
  - Ovarian cancer? _____ Yes _____ No
  - Other cancers? _____ Yes _____ No
  - Osteoporosis? _____ Yes _____ No
  - Heart disease?_____ Yes _____ No
- If you have been pregnant, please indicate how many:
  - Pregnancies: _____ Abortions: _____ Living Children: _____
  - Full-term live births: _____ Premature Births: _____

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Patient's Name: ___________________________________   DOB: _________________

You are on our schedule for a ***WELL EXAM*** today. If you discuss other medical concerns you may incur additional charges, which your insurance plan may determine is your responsibility. Consequently, you may have to pay a co-pay or deductible/co-insurance for the additional services rendered on the same day as your well exam.

Do you have other medical concerns that you would like to make the provider aware of?
Please note: There may not be sufficient time to perform a Well Exam and address other concerns within a single visit*

1.____

2.____

3.____

Which prescriptions do you need refilled today?
Due to the complexity of some conditions, ***not all prescription refills may be addressed today.***

Name of Medication to be REFILLED	Pharmacy (Name and cross streets)

*******Speak with the Medical Assistant to prioritize your needs today******

Signature:______________________________________   Date:_________________________