

Women's Wellness Exam Checklist

Patient Information

Full Name: _____

Date of Birth: ____ / ____ / ____

Contact Number: _____

Email Address: _____

Health History Review

- ☐ Current medications and supplements: _____
- ☐ Past surgeries or hospitalizations: _____
- ☐ Family medical history: _____
- ☐ Personal medical history: _____
- ☐ Allergies (medications, food, environmental): _____
- ☐ Immunization status: _____

Vital Signs Check

- ☐ Blood pressure: _____
- ☐ Heart rate: _____
- ☐ Respiratory rate: _____
- ☐ Temperature: _____
- ☐ Weight: _____
- ☐ Height: _____

General Physical Exam

- ☐ Head and neck exam: _____
- ☐ Thyroid check: _____
- ☐ Lung auscultation: _____
- ☐ Heart auscultation: _____
- ☐ Abdominal exam: _____

☐ Skin check:_____

Women's Health Specifics

☐ Breast exam:_____

☐ Pelvic exam:_____

☐ Pap smear (if due):_____

☐ Human Papillomavirus (HPV) testing (if due):_____

☐ Sexual health discussion:_____

☐ Contraception counseling:_____

☐ Menstrual cycle review:_____

☐ Menopause management (if applicable):_____

Screenings and Tests

☐ Cholesterol screening:_____

☐ Diabetes screening:_____

☐ Bone density scan (if applicable):_____

☐ Mammogram (if due):_____

☐ Colon cancer screening (if due):_____

☐ STI screenings (as indicated):_____

Lifestyle and Wellness

☐ Nutrition and diet review:_____

☐ Physical activity assessment:_____

☐ Mental health screening:_____

☐ Sleep quality assessment:_____

☐ Tobacco, alcohol, and substance use assessment:_____

☐ Stress management discussion: _____

Preventive Health Counseling

☐ Vaccinations update: _____

☐ Cancer prevention tips: _____

☐ Heart health recommendations: _____

☐ Osteoporosis prevention (if applicable): _____

Patient Questions and Concerns

☐ List any specific concerns or symptoms: _____

☐ List any questions for the healthcare provider: _____

Plan and Recommendations

☐ Follow-up appointment scheduling: _____

☐ Referrals to specialists (if needed): _____

☐ Prescriptions or medication adjustments: _____

☐ Recommended lifestyle modifications: _____

☐ Educational materials or resources provided: _____

Healthcare Provider's Signature: _____ **Date:** ____ / ____ / ____

Patient Acknowledgment

- I have discussed the above items with my healthcare provider and understand the recommendations provided.

Patient's Signature: _____ **Date:** ____ / ____ / ____