ANNUAL FEMALE PHYSICAL EXAMINATION FORM

Part One: TO BE COMPLETED PRIOR TO MEDICAL APPOINTMENT

Name: _____ Date of Exam: _____

Address: _____ Date of Birth: _____

DIAGNOSES/SIGNIFICANT HEALTH CONDITIONS *(Attach Lifetime Medical History Summary and Chronic Health Problems List)*

CURRENT MEDICATIONS *(Attach a second page if needed):*

Medication Name	Dose	Frequency	Diagnosis	Prescribing Physician Specialty	Date Medication Prescribed

Allergies/Sensitivities: _____

Contraindicated Medication: _____

CBC/Differential (if performed)

Date: _____ **Results:** _____

Other *(specify)* _____**Date:** _____**Results:** _____

_____

Date of LMP: _____ **Number of Live births:** _____

Hx of ovarian Cysts: _____ **Date of last mammogram:** _____

Part Two: GENERAL PHYSICAL EXAMINATION

Blood Pressure: _____/_____ **Pulse:** _____ **Respirations:** _____ **Temp:** _____ **Height:** _____ **Weight:** _____

EVALUATION OF SYSTEMS

System Name	Normal findings?	Comments/Description

Eyes	Yes No	
Ears	Yes No	
Nose	Yes No	
Mouth/Throat	Yes No	
Head/Face/Neck	Yes No	
Breasts	Yes No	
Lungs	Yes No	
Cardiovascular	Yes No	
Extremities	Yes No	
Abdomen	Yes No	
Gastrointestinal	Yes No	
Endocrine	Yes No	
Musculoskeletal	Yes No	
Integumentary	Yes No	
Renal/Urinary	Yes No	
Reproductive	Yes No	
Lymphatic	Yes No	
Nervous System	Yes No	
VISION SCREENING	Yes No	Is further evaluation recommended by specialist? Yes No
HEARING SCREENING	Yes No	Is further evaluation recommended by specialist? Yes No

Additional Comments:

Recommendations for health maintenance: *(including need for lab work at regular intervals, exercise, hygiene, weight control, etc.)*

Recommended diet and special instructions: _____

Limitations or restrictions for activities *(including work day, lifting, standing, and bending)* No Yes *(specify):* _____

Change in health status from previous year? No Yes *(specify):* _____

Specialty consults recommended? No Yes *(specify)* _____

Clotting Disorder present? No Yes *If Yes, specify type:* _____

Name of physician *(please print)* **Physician's Signature** **Date**

Physician Address: _____ **Physician Phone Number:** _____