Wichita State University
Student Health Services
1845 Fairmount 209 Ahlberg Hall
Wichita, KS 67260-0092
316-978-3620 Fax 316-978-3517

WELL WOMAN EXAM FORM

______Initial Exam

______Annual

Name_______________________________________My WSU ID #____________________
Last First Middle

Date of Birth____________________________________Marital Status: S M W D

Address____Telephone____________________
Street City State Zip Code

Next of Kin_____________________________________Telephone____________________
Name Relationship

Family Physician_________________________________Telephone____________________

FAMILY MEDICAL HISTORY

	Age	State of Health	if deceased, cause	age at death
Father				
Mother				
Brother(s)				
Sister(s)				

SMOKING:

Do you smoke?_________

If yes, # per day_________

Never smoked_________

Stopped (date)_________

Has any blood relation (parent, brother/sister) had: _______Asthma/hay fever_______Cancer_________Diabetes

_______Heart Trouble/Stroke, Clots______High Blood Pressure_____Kidney trouble_________Thyroid Disease_____Tuberculosis

PERSONAL MEDICAL HISTORY: Have you ever had or do you have now: (please check at left of each item)

___Abnormal Pap Smear
___Alcohol/Drug Use
___Anemia
___Asthma/Hay fever
___Bleeding disorders
___Bloody urine
___Cancer/Leukemia
___Chicken Pox
___Chronic cough
___Convulsions
___Diabetes
___Dysentery
___Eating Disorder
___Encephalitis
___Epilepsy
___Frequent headaches
___Gallbladder disease
___Goiter/Thyroid treatment
___Heart murmur
___Heart trouble
___Hepatitis B
___High blood pressure
___Hodgkin's disease
___Infectious Mononucleosis
___Jaundice
___Kidney trouble
___Liver disease
___Malaria
___Measles
___Meningitis
___Migraine headaches
___Pain in chest
___Pleurisy
___Pneumonia
___Rectal Trouble
___Rheumatic fever
___Rubella
___Scarlet fever
___Sinusitis
___STD/STI
___Strep throat
___Tuberculosis

Serious illnesses or hospitalizations (list)____

Surgeries or injuries (broken bones, head injury, etc.)______________________________________

Allergy to drugs, food, plants, other____

Current medications____

Age menstrual periods began________Date of last menstrual period______________Number of days from period to next__________

Days of flow___________Heavy_________Medium________Light__________Pain with periods ________Abnormal periods_______

Age at first intercourse_______________Number of pregnancies____________Number of deliveries______Any abortions_________

Type of contraceptive__________________Number of partners in last 6 months_________How long with present partner_________

Date of last Pap Smear__________Any Abnormal Pap Smears_______Type of treatment_______________________________

Physical Examination Student's Name____________________________________

Blood Pressure_____________Pulse________Weight____________Height____________LMP______________

Normal	Abnormal	Check appropriately and describe abnormalities.
______	______	Head, Scalp and Face__________________________
______	______	Eyes________Date of Last Exam_______________
______	______	Vision:______with glasses______without glasses
______	______	Right:_______________________|_______________
______	______	Left:________________________|_______________
______	______	Color Vision:________________|_______________
______	______	Ears____
______	______	Nose____
______	______	Mouth and throat_____________________________
______	______	Teeth______________Last Exam:_______________
______	______	Neck____
______	______	Lungs____
______	______	Heart____
______	______	Breasts______________________________________
______	______	Abdomen______________________________________
______	______	Rectal_______________________________________
______	______	Hernia_______________________________________
______	______	Adenopathy___________________________________
______	______	Musculo-skeletal_____________________________
______	______	Neurological_________________________________
______	______	Skin____
______	______	Femoral and pedal pulses_____________________
______	______	PELVIC:
______	______	Ext. Gent and Bus____________________________
______	______	Vagina_______________________________________
______	______	Cervix_______________________________________
______	______	Uterus______AF_______M_______RF________
______	______	Adnexa_______________________________________
______	______	Recto-Vag____________________________________

Labwork: ____________Pap Smear_________GC_________Chlamydia_________UA_________CBC

______Rubella Titer________RPR________Other:____

Date of last Tetanus (Td) vaccine:__________________________

Summary of student's health:

a. Physical:____

b. Mental:____

c. Recommendations for follow up:____

d. Immunizations reviewed_____________copies made________copied to Immunization record___________

Date of Exam________________________Examined by:____________________________________

Signature of Physician/APRN/PA____Degree____________

Address____