

Adult Female Health Maintenance Form

Name: _____

Date of Birth: _____

Dental regular dental visits (yearly)

Vision° no correction regular eye exams (yearly)
 glasses
 contacts

Hearing° normal hearing decreased hearing hearing aids

Lifestyle

Diet I eat a normal healthy diet

I have concerns about my weight: _____

Exercise° _____ times/week _____ min/session _____ type of exercise

Reproductive Health

Menstrual Problems° LMP: _____

Flow light medium heavy

Cycle regular irregular

Duration regular irregular

Problems painful periods (dysmenorrhea) missed periods

Sexually Active°

sexually active monogamous relationship multiple partners

Contraceptive° type _____ partner has vasectomy

not sexually active°

Pregnancy History°

of pregnancies _____ # of living children _____

Cancer Screening° - Date of:

_____ last pap smear

_____ last mammogram

_____ last colonoscopy

Metabolic Screen - Date of:

_____ last DEXA/bone density scan