Gilead Annual Medical Examination
Well Woman

Part 1: Personal Particulars

Name:		
Medical Record No.:	**Date of Birth:**	**Age:**
Marital Status: Single/Married/Divorced/Widowed/Separated		
Lives: □Alone	□ **with**	
Parity:	**Age of Last Child:**	
Present Occupation:		
Past Occupation, if any:		

Permanent Address:
Office / Business Address:
Telephone Number(s):
E-mail:

Part 2: History

Part 2.1: Family Medical History

Has any member of your family (paternal or maternal family) ever had any of the following?

Condition	Yes	No
Hypertension		
Stroke, Heart Disease		
Asthma		
Sickle Cell Disease		
Glaucoma		
Epilepsy		
Cancer of the: Breast, Cervix, Colon, Rectum		

Part 2.2: Personal Medical History

a. Have you ever been admitted in a hospital before? Yes / No

If yes,

When .....

How long .....

Where .....

What for .....

b. Have you ever had an accident or serious injury? Yes / No

If yes,

When ……

Where ……

What injury / injuries did you sustain ……

c. Have you had any surgery done on you before? Yes / No

If yes,

What surgery ……

When ……

Where ……

What was the result of the surgery ……

d. Have you ever had any complication of pregnancy or labour? Yes / No

If yes,

What complication ……

When ……

Treatment and or / result ……

e. Do you have, or have you ever had, any of the following conditions?

Condition	Yes	No	If yes, for how long
Hypertension / Pace Maker			
Diabetes			
Asthma			
Sickle Cell Disease			Haemoglobin genotype, if known
Glaucoma			
Epilepsy			
Cancer of the: Breast, Cervix, Colon, Rectum			
Peptic Ulcer			
Haemorrhoids			
Allergies (e.g. rhinitis, allergic conjunctivitis, urticarial, drug allergy)			For drug allergies, state which drugs
Uterine Fibroids			
Breast Disease (Infection, lump, unusual nipple discharge)			
HIV Infection			

Part 2.3: Immunization History

Type of immunization	Year(s) of immunization
Hepatitis B	
Meningitis	
MMR	
Influenza	
Tetanus	
Other	

Part 2.4: Drug History

a. Are you on any medication(s)? Yes / No
If yes, provide the following details

Drug	Dose	How long / since when

b. Do you smoke? Yes / No
If yes,

How many sticks a day ……

For how long have you been smoking?……

If you have stopped smoking, for how long did you smoke? ……

How many sticks were you smoking daily? ……

When did you stop smoking? ……

c. Do you drink? Yes / No
If yes,

How many tots of spirit, glass of wine or bottles of bee a week ……

For how long have you been drinking?……

If you have stopped drinking, for how long did you drink? ……

How much were you drinking a week? ……

When did you stop drinking? ……

d. **Do you use any substance? Yes / No**
If yes, specify ……

Part 2: Systemic Enquiry

2.5.1: General

a. **Have you had weight loss / weight gain in the past six months?** Yes / No
If yes, please elaborate

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b. **Have you had any unusual swellings anywhere on your body?** Yes / No
If yes,

How long have you had the swelling ……

Does it give you pain ……

Do you know how the swelling came about……

…… ……

2.5.2: Respiratory & Cardiovascular Systems

a. **Do you have chest pain?** Yes / No
If yes,

Where in the chest is the pain located ……

Can you describe how the pain feels like ……

What brings the pain on / makes it worse ……

What makes the pain less / stop ……

Does the pain radiate ……

b. **Do you have a cough?** Yes / No
If yes,

How long have you been coughing ……

Do you bring up any sputum (phlegm)?……

If yes, what is the color or the sputum? ……

c. **Do you difficulty breathing** Yes / No
If yes,

What makes it better? ……

What makes it worst? ……

d. **Do you have palpitations / or feel your heart beats faster than usual?** Yes / No
If yes,

What makes it better? ……

What makes it worst? ……

2.5.3: Alimentary System

a. **Do you have abdominal pain?** Yes / No
If yes,

Please describe the nature of the pain (e.g. biting, gripping or biting, stabbing)……

Where in the abdomen is pain felt most?……

When does the pain come on? ……

What makes the pain better? ……

What makes the pain worst? ……

Does the pain radiate? Yes / No……

If yes, where does the pain radiate? ……

b. **Do you have nausea or feel like vomiting?** Yes / No
If yes,

What brings about the nausea……

Do you vomit? Yes / No……

If yes, what time of the day? ……

How many times in a day? ……

c. **Do you have indigestion or feel bloated?** Yes / No

d. **Do you have heartburns?** Yes / No
If yes,

What makes it better? ……

What makes it worse?……

e. **Have you noticed any change in your bowel habits or the frequency of going to the toilet?** Yes / No
If yes,

Elaborate……

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Have you been diagnosed with hepatitis in the past?……

f. **Have you noticed blood in your stool?** Yes / No
If yes,

For how long? ……

Is the blood mixed with the stool or do you notice it on the toilet paper?……..

2.5.4: Urinary System

a. **Do you have difficulty in passing urine or strain, hesitancy, irretannt?** Yes / No

b. **Do you have pain in passing urine?** Yes / No
If yes,

Where do you feel the pain? ……

c. **In the last few weeks or months, have you been urinating more frequently than usual? Yes / No**
If yes,

Since when? ……

How many times do you urinate from the time you wake up in the morning till you go to bed at night……..

How many times do you wake up in the night to pass urine……..

d. **In the last few weeks or months, have you been drinking water more frequently than before? Yes / No**

e. **Have you ever passed blood in your urine? Yes / No**
If yes,

When was this? ……

For how long? ……

How were you cured? ……

Was the blood mixed with your urine or was it at the end of the urination?……

2.5.5: Reproductive System

a. **If you are still menstruating? Yes / No**
If yes,

When did your last menses start? ……

Do you have any problem with your menses? Yes / No

If yes, Elaborate……

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When did the problem start?……

b. **If your menses have ceased:**

At what age did your menses cease? ……

Do you have any symptoms? Yes /No

If yes, Elaborate……

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c. Have you ever had a D&C or miscarriage? Yes / No:

If yes,

How many times ……

d. Do you have a discharge from the vagina? Yes / No:

If yes,

For how long…….. ……

What is the color? …….. ……

Any associated pain? …….. ……

Any associated itching? …….. ……

2.5.6: Musculoskeletal System

a. Do you have any joint pain? Yes / No
If yes,

Which joint? ……

For how long? ……

b. Do you have any joint swellings? Yes / No
If yes,

Which joint? ……

For how long? ……

2.5.7: Skin

a. Do you have a skin rash? Yes / No
If yes,

Describe (Nature, location, itch)? ……

2.5.8: Central Nervous System

a. **Have you ever had a stroke?** Yes / No
If yes,

Which joint? ……

For how long? ……

b. **Do you have seizures?** Yes / No
If yes,

Since when? ……

How often? ……

c. **Do you have any problem with your sight?** Yes / No
If yes,

What problem? ……

For how long? ……

What treatment have you been given? ……

When did you last see your eye specialist? ……

d. **Do you have any problem with your hearing?** Yes / No
If yes,

What problem? ……

For how long? ……

e. **Do you have any problem with your sense of smell?** Yes / No
If yes,

What problem? ……

For how long? ……

How did it happen? ……

2.5.8: Mental Health

a. **Have you ever had to see a psychiatrist/Psychologist in the past?** Yes / No
If yes,

What was the reason? ……

When did you last see him / her? ……

Are you on any medication(s) from the psychiatrist? Yes / No

If yes, name(s) and dose(s) of drugs prescribed ……

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Part 3: Physical Examination

3.1: General

a. General condition/appearance

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b. Vitals

Weight…….. **Height**…… **BMI**……

- Pallor
- Jaundice
- Scalp, skin and nails
- Ears & nose
- Mouth, teeth & tongue
- Throat
- Lymph nodes

3.2: Respiratory System

Respiratory rate ……

Inspection ……

Vocal fremitus ……

Percussion note ……

Auscultation ……

3.3: Cardiovascular System

Neck veins ……

Pulse ……

Blood pressure ……

Heart sounds ……

Murmur ……

3.4: Abdomen

Inspection ……

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Palpation

- Liver ……
- Spleen ……
- Kidneys ……
- Other ……

Percussion ……

Bowel sound ……

Hernia orifices ……

3.5: Reproductive System

Inspection ……

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Vaginal examination (Pap smear) ……

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Breast examination ……

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3.5: Reproductive System

Inspection ……

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Vaginal examination (Pap smear) ……

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Breast examination ……

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3.5: Central Nervous System

Eyes

- Visual acuity ……
- Intraocular pressure ……
- Color vision ……
- Reaction to light ……

Mental Status ……

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Muscle tone

- Power ……
- Right ……
- Left ……

Tendon reflexes

- Sensation ……
- Touch ……
- Pain ……