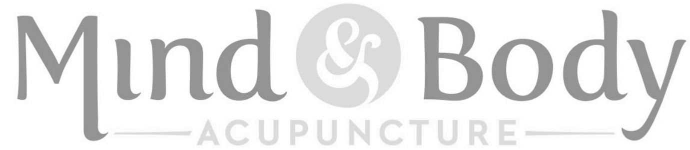

FEMALE HEALTH

Patient Name: ____

MENSTRUAL/HORMONAL

1. Age at which menses began: ____________________ 2. Did you have any problems? **Y N**

If yes, please explain: ____

3. Date of last two menstrual periods: _____/_____/_____ and _____/_____/_____

4. Do your periods come at regular intervals? **Y N**

5. How many days do you normally bleed? ___________

6. How many days from onset to onset? ___________

7. How heavy is the bleeding? **Light Medium Heavy**

8. Do you bleed or spot between periods? **Y N**

9. What color is the blood? **Light Red Red Dark Red Purple Brown Black**

10. Is there clotting? **Y N**

11. Do you have premenstrual symptoms? **Y N**

( ) Irritability ( ) Low Back Pain ( ) Constipation ( ) Diarrhea ( ) Cramping
( ) Water Retention ( ) Cravings ( ) Acne ( ) Breast Tenderness

12. If you have any of these symptoms, when in the cycle do they occur and for how long?

____

13. Are your periods painful? **Y N** If so, when and how long does it last?

____

14. Have you had any of the following?

( ) Hot Flashes
( ) Breast discharge
( ) Visual Disturbance
( ) Chronic Headache
( ) Increased facial/body hair
( ) Vomiting
( ) Weight Increase > 10 lbs
( ) Weight Decrease < 10 lbs
( ) Extraordinary Stress

PREGNANCY HISTORY

1. Pregnancies _____ 2. Term Births _____ 3. Premature Births _____ 4. Miscarriages _____
5. Elective Abortion _____

Date	Miscarriage	Elective Abortion	D&C	Ectopic Pregnancy	Infertility Treatment	Weight & Sex	C-Section	Complications	Is current partner the father?

CONTRACEPTION USE

Type	From When to When	Reason discontinued

GYNECOLOGICAL

1. Have you ever had an abnormal pap smear? **Y N** 2. Date of last pap smear? ___________

3. Do you get yeast infections regularly? **Y N** 4. Do you douche regularly? **Y N**

5. Have you had an STD (sexually transmitted disease)? **Y N**

If yes, what was it and how was it resolved? ____

6. Do you have chronic vaginal discharge? **Y N**

7. Do you have any sores on your genitalia **Y N**

8. Have you ever had a cervical biopsy, operation, cauterization, or freezing (cryo)? **Y N**

If so, please explain: ____

9. Have you ever had pelvic inflammatory disease (PIV)? **Y N**

10. If yes, were you treated for it? **Y N** How? ________________________________

11. Have you ever been diagnosed with uterine fibroids or polyps? **Y N**

12. Have you ever been diagnosed with endometriosis? **Y N**

15. Have you ever been diagnosed with PCOS (Polycystic Ovarian Syndrome)? **Y N**