Women's Health History

General

Date of last pap smear: ________________ Was it normal or abnormal? ___________________

Do you have a history of abnormal pap smears? ____

History of yeast infections? _____________ Vaginal discharge: __________________________

History of Urinary Tract Infections? _____ If so, when? ________________________________

Please explain any concerns you may have with sexual function and/or libido:

____

Have you been diagnosed with any of the following?

___ Fibroids ___ Ovarian Cysts ___ PID ___ STD's (list) _________

___ Endometriosis ___ PCOS ___ Anemia ________________________

Menstruation

Age at first menses: ____________________ Date of last menstruation: _____________________

Duration of flow: __________ Days between cycle: __________ Blood clots: __________

Color of menstrual blood: pale bright red dark red brown other _________________

Pain? __________ If so, when? ____

Irregular menses? ____________________ Heavy or light flow? _________________________

Please indicate whether you experience any of the following symptoms during your menses:

___ Low back pain ___ Bloating ___ Nausea ___ Anger/Frustration

___ Headaches ___ Low energy ___ Diarrhea ___ Sadness

___ Breast pain ___ Blood clots ___ Constipation ___ Low appetite

Pregnancy

Are you pregnant/chance you might be? ________ If so, how far along are you? ____________

Number of pregnancies: ________________ Number of live births: ________________________

Number of miscarriages: _______________ Number of abortions: ________________________

History of premature births: _____________ If so, when? _____________________________

Current method of birth control: ____

Menopause

Age at menopause: ____________________ Age now: ___________________________________

Please indicate whether you experience any of the following symptoms:

___ Hot flashes ___ Dry skin ___ Change in mood

___ Night sweats ___ Vaginal dryness Other: ___________________