WOMEN'S HEALTH HISTORY (1 of 2)

Name (Last, First, Middle)	Today's Date

Menstrual History

Age at which menses began __________

Do you menstruate regularly? ❑ Yes ❑ No

If yes, your cycle is __________ days total

Do you menstruate irregularly? ❑ Yes ❑ No

If yes, your cycle varies from _____ to _____ days

When was your last menstrual period? __________

**Note: If you are post-menopausal, please answer the following questions to the best of your recollection.*

Have your cycles changed since they began? ❑ Yes ❑ No

How? ______________________________________

Do you know if you ovulate? ❑ Yes ❑ No

If yes, on what day? __________

How do you know? __________________________

____

____

Do you have PMS symptoms? ❑ Yes ❑ No

If yes, check all that apply: ❑ Acne

❑ Bowel Changes ❑ Breast Changes

❑ Cramp/Backache ❑ Food Cravings

❑ Irritability/Anger ❑ Nausea ❑ Sad/Weeping

❑ Others __________

Do you experience cramps ❑ Before ❑ During ❑ After menstruation?

How many days per cycle do you menstruate? __________

Do you spot between periods? ❑ Yes ❑ No

During your period, the flow is:

❑ Light/Spotting on days __________

❑ Medium on days __________

❑ Heavy on days __________

❑ With clots on days __________

What color is the blood?

❑ Light Red on days __________

❑ Bright Red on days __________

❑ Dark Red on days __________

❑ Purple on days __________

❑ Brown on days __________

❑ Black on days __________

Do you have symptoms just after menstruation? ❑ Yes ❑ No

If yes, check all that apply: ❑ Dizziness ❑ Fatigue

❑ Insomnia ❑ Night sweats ❑ Others __________

Do you experience any of the following? ❑ Day sweats

❑ Hot Flashes ❑ Insomnia ❑ Night sweats ❑ Vaginal Dryness

❑ Others __________

What age did you begin perimenopause? __________

What age did you experience menopause? __________

Reproductive History

What birth control have you used in the past?
(ie. BC Pill, 2001-Present)

____

____

____

____

____

____

____

____

Are you currently using birth control? ❑ Yes ❑ No

Are you currently trying to conceive? ❑ Yes ❑ No

If yes, how long have you been trying to conceive? __________

WOMEN'S HEALTH HISTORY (2 of 2)

Name (Last, First, Middle)	Today's Date

Reproductive History (cont.)

How is your sexual energy? ❑ High ❑ Medium ❑ Low

How is your partner's sexual energy? ❑ High ❑ Medium ❑ Low

	Number	Years
How many pregnancies have you had?	______	_____________
How many children do you have?	______	_____________
How many abortions have you had?	______	_____________
How many miscarriages have you had?	______	_____________

Have you had any high-risk pregnancies? ❑ Yes ❑ No

Have you had difficult labor/deliveries? ❑ Yes ❑ No

Have you had postpartum concerns? ❑ Yes ❑ No

Have you had lactation concerns? ❑ Yes ❑ No

Breast Health

Do you have any of the following? ❑ Breast Lumps/Nodules

❑ Breast Cancer ❑ Breast Tenderness ❑ Inverted Nipples

❑ Nipple Discharge ❑ Mastitis

❑ Family History Of Breast Cancer ❑ Others __________

Date of last mammogram __________

General Gynecology

Do you have chronic vaginal discharge? ❑ Yes ❑ No

Do you get yeast infections regularly? ❑ Yes ❑ No

Have you ever been diagnosed with any of the following?

❑ Cancer Of Reproductive Organs ❑ Cysts ❑ Endometriosis

❑ Fibroids ❑ Pelvic Abnormalities/Adhesions ❑ PID ❑ STDs

❑ Others __________________________

Date of last pap smear __________

Have you ever had an abnormal pap smear? ❑ Yes ❑ No

Do you have a family history of cancer of the reproductive organs?

❑ Yes ❑ No

Additional Information