Name: _____ Today's Date: _____ Date of Birth: _____

Women's History

Obstetric History: *(Check box and provide number if applicable)*

☐ Pregnancies _____ ☐ Miscarriages _____ ☐ Abortions _____ ☐ Living children _____
☐ Vaginal deliveries_____ ☐ Cesarean _____ ☐ Term births _____ ☐ Premature birth_____

Birth weight of largest baby_____ Birth weight of smallest baby _____

Did you develop any problems in or after pregnancy, for example, toxemia (high blood pressure), diabetes, post-partum depression, issues with breast feeding, etc.? ☐ Yes ☐ No
If yes, please explain _____

Menstrual History:

Age at first period _____ Date of last menstrual period _____
Length of cycle _____ Time between cycles _____

Cramping? ☐ Yes ☐ No Pain? ☐ Yes ☐ No

Have you ever had premenstrual problems (bloating, breast tenderness, irritability, etc.)? ☐ Yes ☐ No
If yes, please describe:_____

Do you have other problems with your periods (heavy, irregular, spotting, skipping, etc.)? ☐ Yes ☐ No
If yes, please describe:_____

Use of hormonal birth control: ☐ Birth control pills ☐ Patch ☐ Nuva ring
☐ Other_____ How Long _____

Any problems with hormonal birth control? ☐ Yes ☐ No
If yes, explain _____

Use of other contraception? ☐ Yes ☐ No ☐ Condoms ☐ Diaphragm ☐ IUD ☐ Partner vasectomy

Are you in menopause? ☐ Yes ☐ No If yes, age at last period:_____

Was it surgical menopause? ☐ Yes ☐ No If yes, explain surgery:_____

_____

Do you currently have symptomatic problems with menopause? *(Check all that apply)*

☐ Hot flashes ☐ Mood swings ☐ Concentration/memory problems ☐ Headaches ☐ Joint pain
☐ Vaginal dryness ☐ Weight gain ☐ Decreased libido ☐ Loss of control of urine ☐ Palpitations

Are you on hormone replacement therapy? ☐ Yes ☐ No
If yes, for how long and for what reason (hot flashes, osteoporosis prevention, etc.)?_____

_____

Other Gynecological Symptoms: *(Check if applicable)*

☐ Endometriosis ☐ Infertility ☐ Fibrocystic breasts ☐ Vaginal infection ☐ Fibroids
☐ Ovarian cysts ☐ Pelvic inflammatory disease ☐ Reproductive cancer
☐ Sexually transmitted disease (describe) _____

_____

Gynecological Screening/Procedures: *(If applicable, provide date)*

Last Pap test: _____ ☐ Normal ☐ Abnormal
Last mammogram: _____ ☐ Normal ☐ Abnormal
Last bone density: _____ Results: ☐ High ☐ Low ☐ Within Normal Range
Other tests/procedures (list type and dates)_____

_____