

Name: _____ Age: _____ DOB: _____ Occupation: _____

Referred by: _____ Primary Care Doctor: _____

Date: _____ Reason for Visit: _____

MENSTRUAL HISTORY

First day of last period	_____			
Age of first period	_____	Age periods stopped	_____	<i>This column for doctor's use only</i>
Usual duration	_____	# Days from one period to the next	_____	
Any bleeding between periods?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Any bleeding after intercourse?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Bleeding as heavy as soaking a super pad or tampon in an hour for several hours?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Painful periods that you take medication for?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____

IF YOU ARE MENOPAUSAL

Have you ever taken hormones?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Are you taking hormones now?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____

BIRTH CONTROL

Current Method:	_____	_____	
Previous Methods	_____	_____	
Are you planning pregnancy in the future?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____

GYNECOLOGIC HISTORY

Date of last Pap smear	_____	Where: _____	_____
Have you ever had:			
An abnormal Pap smear?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Colposcopy (microscopic look at cervix)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Freezing/burning/LEEP of the cervix?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Genital Herpes?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Chlamydia, Gonorrhea or PID?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Syphilis, Hepatitis B, or C, or HIV	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Endometriosis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Fibroids?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Have you ever been:			
Infertile?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
DES exposed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Do you have:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Unusual discharge, odor or itching?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____

SEXUAL HISTORY

My primary sexual partner at this time:			
<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Both <input type="checkbox"/> No one			_____
How long have you been sexual with this partner?	_____		_____
Have you had more than 3 sexual partners?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Do you have pain with intercourse?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Have you ever been abused sexually, verbally or physically by anyone?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____

BREASTS

Date of last mammogram:	_____	Where: _____	Are you experiencing breast pain?	<input type="checkbox"/> Y <input type="checkbox"/> N
Have you had breast surgery?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Are you experiencing nipple discharge?	<input type="checkbox"/> Y <input type="checkbox"/> N
Do you perform breast exams monthly?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you have a breast lump?	<input type="checkbox"/> Y <input type="checkbox"/> N

OBSTETRIC HISTORY

	G _____	P _____	SAB _____	TOP _____	ECTOPIC _____
# of Vaginal Deliveries	_____	Year(s) of Vaginal Deliveries	_____		
# of C/Sections	_____	Year(s) of C/Sections	_____		
# of Miscarriages	_____	Year (s) of Miscarriages	_____		
# of Ectopic Pregnancies	_____	Year (s) of Ectopic Pregnancies	_____		
# of Abortions	_____	Year (s) of Abortions	_____		