

Women's Health History - Confidential

Patient name:

Age at which menses began

How many days do you normally bleed?

Your bleeding is? Light Normal Heavy

What color is the blood? Light red Red Dark red Purple Brown Black

Is there clotting? Yes No

Are your menstrual cycles spaced regularly? Yes No

How many days are there from one period to the next? Yes No

Do you bleed or spot between periods? Yes No

Have your cycles changed since they began? Yes No

How?

How many days does the pain last?

Are your periods painful? Yes No

Do you have a **p**remenstrual tension? Yes No

Do your breasts become tender **p**remenstrually? Yes No

Do you get premenstrual low back pain? Yes No

Are your bowel movements loose at the beginning of your period? Yes No

How many pregnancies have you had? How many children do you have?

How many abortions have you had? How many miscarriages have you had?

How many times D&C been performed?

Have you ever had a cervical biopsy, cauterization or conization? Yes No

Do you get yeast infections often? Yes No

Do you have vaginal discharge? Yes No

Do you have any sores on your genitalia? Yes No

Have you ever had pelvic inflammatory disease? Yes No

Were you treated for it? Yes No

How?

Date of last Pap smear

Have you ever been diagnosed with uterine fibroids or polyps? Yes No

Have you ever been diagnosed with endometriosis? Yes No

Have you been diagnosed with pelvic adhesions? Yes No

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- Do your breasts get tender at/during ovulations? Yes No
- Do you have pain or cramping during ovulation? Yes No
- Have you, or are you currently going through menopause? Yes No

If yes, please list your symptoms:

Symptom	Onset	Medications
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How is your sexual energy?

Low Normal High

Do you have excessive facial hair? Yes No

Do you have excessively oily skin? Yes No

Have you experienced excessive loss of head hair? Yes No

Have you been exposed to any known environmental toxins or hormones?
Yes No