Women's Health History

CONFIDENTIAL

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NAME (LAST, FIRST, MIDDLE) DATE

Age at which menses began _____

Are your periods painful? Yes No

How many days does the pain last? _____

How many days do you normally bleed? _____

How heavy is the bleeding? Light Normal Heavy

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

Is there clotting? Yes No

Do you have premenstrual tension? Yes No

Does your face break out before or during your period? Yes No

Do your breasts become tender premenstrually? Yes No

Do you bleed or spot between periods? Yes No

Are your menstrual cycles spaced irregularly? Yes No

How many days are there from one period to the next?_____

Date of last menstrual period_____

	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?	_____	_____
How many times D&C been performed?	_____	_____

Have you ever had an abnormal pap smear? Yes No

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

Have you ever had a venereal disease? Yes No

Do you get yeast infections regularly? Yes No

Have you ever been diagnosed with Chlamydia? Yes No

Do you have chronic 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

Have you been diagnosed with any pelvic abnormalities? Yes No

Have you taken any medications for gynecological conditions other than contraceptives? Yes No

Medication	**Reason**	**How Long**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have your cycles changed since they began? Yes No

How?_____

Do you ovulate on your own? Yes No

On what day of your cycle?_____

What method do you use to determine ovulation? _____

Do your breasts get tender at/during ovulations? Yes No

Do you have pain or cramping during ovulation? Yes No

Do you get premenstrual low back pain? Yes No

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

Women's Health History *Continued*

Have you, or are you currently going through menopause?
☐ Yes ☐ No

If yes, please list your symptoms:

Symptom	Onset	Medications
_____	_____	_____
_____	_____	_____
_____	_____	_____

How is your sexual energy? ☐ Low ☐ Normal ☐ High

Do you douche regularly? ☐ Yes ☐ No

Do you use vaginal lubricants? ☐ Yes ☐ No

Are you more than 20% over your ideal body weight? ☐ Yes ☐ No

Are you more than 20% below your ideal body weight? ☐ Yes ☐ No

Do you have a stressful occupation? ☐ Yes ☐ No

Do you exercise regularly? ☐ Yes ☐ No

What do you do for exercise? _____

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 noticed discharge from your nipples? ☐ Yes ☐ No

Was your mother exposed to diethylstilbestrol (DES)
when she was pregnant with you? ☐ Yes ☐ No

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

Are you presently taking steroids? ☐ Yes ☐ No

COMMENTS / NOTES

Fertility Patients Only

How long have you been trying to conceive?_____

Have you had fertility treatments? ☐ Yes ☐ No

If yes, when and where?_____

By whom?_____

What types?_____

Have you taken medication to help you ovulate? ☐ Yes ☐ No

When? _____

Have your fallopian tubes been evaluated medically? ☐ Yes ☐ No

What were the results?_____

Have you had any tubal operations? ☐ Yes ☐ No

Have you had any hormone laboratory tests performed? ☐ Yes ☐ No

What were the results? _____

Do you have a single partner with whom you have been trying to conceive? ☐ Yes ☐ No

How long have you been married or living together?_____

Has he had a fertility workup? ☐ Yes ☐ No

What were the results?_____

Is your partner supportive of your wish to conceive? ☐ Yes ☐ No

Have you taken oral contraceptives? ☐ Yes ☐ No

When?_____What kind?_____

Have you ever had an IUD? ☐ Yes ☐ No

When?_____

Have you had a diagnosis relating to infertility? ☐ Yes ☐ No

What was it?_____

COMMENTS / NOTES