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Name _____ DOB _____ Marital Status ____ Date _____

Menstrual History

If menopausal, at what age did your periods stop? _____
Number of days between first day of one and first day of next period? _____
Length of period? _____ Regular or Irregular _____
Would you call your periods ( ) light ( ) medium ( ) heavy ( ) clots
When was the first day of your last menstrual period? _____ Do you have cramps?_____
Was it a normal period? _____ If not, when was the last normal one? _____
Would you like information on a simple, safe procedure performed in our office that can significantly reduce or eliminate your monthly periods/cramps? __Y __N

Contraception- (If premenopausal)

What is your current form of birth control?
Abstinence Birth Control pill Hysterectomy IUD Menopause Tubal ligation Vasectomy Nuvaring Patch Depoprovera Rhythm Condoms
How long have you been using your current form of birth control? (please check one)
__ 2 yrs or less __ 3-5 yrs __ 6-10 yrs __ over 10 yrs
When are you planning to have another child? (please check one)
__ within 1-2 yrs __ within 5-10 yrs __ my family is complete

Review of Symptoms: (Circle current symptoms)

GENERAL- Fatigue Fever Weight gain Weight loss
CARDIOVASCULAR- Palpitations Chest pain
PULMONARY- Cough Shortness of breath
GASTROINTESTINAL- Bloating Constipation Diarrhea Hemorrhoids Bloody stools Nausea
URINARY- Pain with urination Blood in urine Frequency UTI's Incontinence
GENITAL- Irregular periods Painful intercourse History of sexual abuse Vaginal discharge Vaginal itching
MUSCULOSKELETAL- Back pain Joint pain
Breast- Perform self breast exams-Regularly/Irregularly/Never Masses Tenderness Nipple discharge
SKIN- Rash Warts
NEUROLOGICAL- Dizziness Headache
BLOOD/LYMPHATIC- Easy bruising Bleeding easily History of blood transfusion Enlarged lymph nodes
ENDOCRINE- Hair loss Temperature intolerance Excessive hair growth
ALLERGIES- Seasonal allergies
PSYCHIATRIC- Anxiety Depression PMS Insomnia