



NAME: _____

DATE: _____

WOMEN'S HEALTH HISTORY

MENSTRUAL HISTORY:

AGE AT FIRST PERIOD _____

PERIODS COME EVERY: _____ DAYS. PERIODS LAST: _____ DAYS. LAST PERIOD BEGAN: _____

DO YOU HAVE: HEAVY BLEEDING SIGNIFICANT CRAMPS
 LONG PERIODS BLEEDING /SPOTTING BETWEEN PERIODS
 IRREGULAR CYCLES

DO YOU USE: TAMPONS PADS BOTH

MEDICATION USED FOR MENSTRUAL CRAMPS: _____

PMS (PREMENSTRUAL SYNDROME) : _____

(PLEASE NOTE DOSAGE AND HOW FREQUENT)

GYNECOLOGICAL HISTORY:

YES NO

____ ____ HAVE YOU EVER HAD A PELVIC EXAM? IF YES, DATE OF YOUR PELVIC EXAM _____

____ ____ HAVE YOU EVER HAD A PAP TEST? IF YES, WHEN WAS YOUR LAST ONE? DATE _____

____ ____ HAVE YOU EVER BEEN TOLD YOU HAD AN ABNORMAL PAP TEST? ____

IF YES, HOW WERE YOU TREATED FOR YOUR ABNORMAL PAP TEST? (REPEAT PAPS, COLPOSCOPY, MEDICATION)
PLEASE EXPLAIN _____

____ ____ HAVE YOU HAD: OVARIAN CYSTS UTERINE/VAGINAL ABNORMALITY PELVIC INFECTION/ SURGERY

____ ____ HAVE YOU EVER BEEN DIAGNOSED OR TREATED FOR A SEXUALLY TRANSMITTED INFECTION?
(GONORRHEA, CHLAMYDIA, HERPES, GENITAL WARTS, HEPATITIS, HIV, SYPHILIS, TRICHOMONIASIS, PEVLIC INFLAMMATORY DISEASE)

____ ____ HAVE YOU HAD VAGINAL INFECTIONS {YEAST, BACTERIAL VAGINOSIS (BV)}?

____ ____ HAVE YOU HAD BREAST PROBLEMS OR CONCERNS (E.G. LUMPS OR DISCHARGE) ? _____

____ ____ HAVE YOU HAD AN ABNORMAL AMOUNT OF HAIR GROWTH (FACIAL, CHEST, ABDOMEN)? _____

____ ____ HAVE YOU EVER HAD A URINARY TRACT INFECTION OR KIDNEY INFECTION? _____

____ ____ IF YES, WAS IT WITHIN THE LAST 6 MONTHS? PLEASE INDICATE MEDICATION TAKEN: _____

PREGNANCY HISTORY: IF APPLICABLE, please fill in the appropriate boxes

_____ # PREGNANCIES _____ # LIVE BIRTHS _____ # MISCARRIAGES _____ # TERMINATIONS _____

CONTRACEPTION HISTORY: IF APPLICABLE, please fill in the appropriate boxes

CURRENT METHOD OF BIRTH CONTROL: BCP _____ PATCH _____ IUD _____ DEPOPROVERA _____ NUVA RING _____ CONDOMS _____
WHEN FIRST BEGAN TAKING? _____ FOR WHAT REASON? _____

WHAT METHODS OF BIRTH CONTROL HAVE YOU USED IN THE PAST (IF DIFFERENT FROM ABOVE) _____

____ ____ DO YOU HAVE QUESTIONS ABOUT SEX YOU WOULD LIKE TO DISCUSS?

____ ____ ANY PAINS OR BLEEDING DURING OR AFTER SEX?