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Women's Health Form

Name: ___________________________________ Birthday/Age: ______ Date: _______________

1. General information

What is your main complaint/ concern and do you have a diagnosis for it? __________________________

____

Are you currently pregnant? Yes No

Do you practice birth control and what contraception method?____________________________________

Last PAP test: _____________________________________

Do you have any other gynecological problems listed below?

___ Fibroids
___ Abnormal bleeding
___ Amenorrhea
___ Painful periods
___ Ovarian cysts
___ Endometriosis
___ Cervical dysplasia
___ Uterine cancer
___ Cervical cancer
___ Polycystic ovary syndrome (PCOS)
___ Ovarian cancer
___ Chronic pelvic pain
___ Infertility (complete Section 9)
___ Painful intercourse
___ Prolapse of bladder / vagina
___ Pelvic infections (complete Section 7)
___ Excessive vaginal discharge
___ Frequent urinary tract infections

Other concerns/ problems: ____

2. History of Periods (Please complete even if no longer having periods)

Onset (age):______ Usual number of days in cycle: __________

Length of cycle (start of period to start of period):_____________

Description of the period

	Pre-period	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7	Day 8 +
Flow(spotting, light, medium, heavy)									
Color of blood (pink, red, purple, brown, black)									
Number of pads/ tampons									
Clots (size: very small, dime-, quarter-size, large)									
Cramping/ Pain Y /N (and intensity: mild, moderate severe)									

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For painful periods
If pain with periods, how would you describe the quality of cramping or pain? (Example: dull, sharp, heavy, stabbing, dragging, etc.) ____
Medications used for pain:____
Pain at ovulation? Yes / No Pain after the period? Yes / No
Please describe: ____
Any abnormal bleeding or changes in the periods? ______________________________
____
Menopause? (see Section 6) Yes / No

3. PMS
PMS starts: ____________________ PMS ends: ______________________
PMS includes (please check all that apply):

___ breast tenderness
___ sore back / knees
___ blurred vision
___ cramping
___ abdominal pain
___ abdominal distention
___ edema of hands / feet
___ generalized edema
___ frequent urination
___ increased/ decreased libido
___ Other (please describe):____

___ constipation
___ loose stool / diarrhea
___ sweating: day /night
___ feelings of heat
___ feeling cold
___ poor sleep
___ poor memory
___ tiredness

___ clumsiness
___ irritability
___ moodiness
___ depression
___ agitation
___ aggressiveness

4. Pregnancies (For infertility treatments, see Section 9)
Number of pregnancies._____ Number of Births:_______
Miscarriages:______ Terminations:_______

Pregnancy history

	Weeks gestation	Live birth (yes / no)	Vaginal/ C-section	Length of labor	Complications/ comments
#1					
#2					
#3					
#4					
#5					
#6					

Were any of your births outside of a hospital? Yes / No
Please explain: ____

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5. Breast treatments/problems

List any breast problems: ____

____

Surgeries/ procedures and dates: ____

____

Practitioner: ______________________
Name: ________________________ Date: ______________

6. For Peri-menopause/ Menopause

Date of last period:__________ Age at menopause:_________

Approximate time/ length of peri-menopause: ___________________________________

Changes from usual periods and timing:_______________________________________

____

Peri-menopausal / Menopausal Symptoms
Please rank by severity as: 1 – mild, 2 – moderate, 3 – severe:

___ hot flashes
___ daytime sweating
___ night sweats
___ insomnia
___ feeling cold
___ tinnitus: hi or low pitch
___ blurred vision
___ dry eyes / dry skin
___ sore low back / knees

___ vaginal dryness
___ increased /decreased libido
___ headaches
___ constipation
___ frequent/ loose stools
___ frequent urination
___ dark scanty urine
___ tiredness

___ anxiety
___ irritability
___ nervousness
___ depression
___ dizziness
___ unable to concentrate
___ forgetful
___ fearful

Medications/ supplements used for menopausal symptoms ___________________________

____

If post-menopausal, do any of these symptoms remain? ____________________________

____

7. Vaginal Discharge

Do you have excessive /unusual vaginal discharge at ovulation? Yes / No

Please describe____

Do you have any abnormal/ excessive vaginal discharge (except at ovulation)? Yes / No

Please describe the amount of discharge, color, consistency, odor, burning, itching, irritation.

____

____

Have you been diagnosed with any of the following?

___ Genital warts

___ Herpes
___ Chlamydia
___ Gonorrhea
___ Candida (yeast infections)
___ Bartholin cysts
___ Other bacterial infections

Treatments and dates:____

Other sexually transmitted diseases (STD) or pelvic inflammatory diseases (PID)? ________________

____

8. GYN Procedures/ Surgeries

Please list any diagnostic procedures, office procedures or surgeries with dates.

____

____

____

____

____

____

9. Infertility and assisted reproductive treatments (Complete only if applicable)

What diagnosis have you been given for infertility? _______________________________________

Diagnostic procedures, treatments, surgeries and dates: ___________________________________

____

____

____

Cycles of IVF /dates/ results

Cycle 1/ Date		
Cycle 2/ Date		
Cycle 3/ Date		
Cycle 4/ Date		
Cycle 5/ Date		

Medications used for infertility: ____

____

Practitioner: ___________________________________

10. Additional Comments