Name: _____DOB:_____ Date: _____

Menstrual/Reproductive History

Menses

Age period began? _____ Date of last period: _____
Regular periods? ❑ No ❑ Sometimes ❑ Yes
Periods every days___(length of time between the start of one period to the start of the next)
Flow: ❑Heavy ❑Medium ❑Light Duration: _____days
Spotting? ❑ No❑ Yes Midcycle: ❑ No❑ Yes Instead of period? ❑ No ❑ Yes
Bloating? ❑No ❑Yes Cyclical premenstrual weight gain: ❑No ❑Yes How much?__lbs.
Cramps? ❑No ❑Yes Duration:___days Intensity: ❑Mild ❑Moderate ❑Severe
PMS? ❑No ❑Yes Describe: _____

Pregnancy

Currently pregnant? ❑No ❑Yes Planning? ❑No ❑Yes When: _____
Prior Pregnancies: # ____ Births: #____Miscarriages: #____Abortions: #____C-sections: #____
Complications? ❑No ❑Yes Describe:_____
Type of birth control: _____
Ever use birth control pills? ❑No ❑Yes How long/When?_____

Hormones

Menopausal? ❑No ❑Yes Ovaries present? ❑No ❑Yes Uterus Present? ❑No ❑Yes
Date Uterus or Ovaries were removed: _____
Hot flashes? ❑No ❑Yes Rx:_____Onset:_____
Frequency: ____times per day/week for____minutes. Intensity: ❑Mild ❑Moderate ❑Severe
Painful intercourse? ❑No ❑Yes Vaginal dryness? ❑No ❑Yes

Breast Exam

Breast pain/lumps? ❑No ❑Yes Breast discharge? ❑No ❑Yes
Date of last mammogram: _____Results: _____
Do you do monthly self-breast exam? ❑No ❑Yes If not monthly, how often? _____

Pelvic Exam

Date of last pelvic exam _____ Reason: _____
Date of last PAP _____Results: _____
Previously abnormal PAP? ❑No ❑Yes Date_____Results_____Therapy_____
Recurring vaginal yeast infections? ❑No ❑Yes Onset:_____Frequency:_____

Is there anything else you would like the Doctor to know?

_____
_____
_____
_____
_____
_____
_____