

Patient Name: _____ Age: _____ Marital Status: _____

Occupation: _____ Would you like a chaperone for this visit: Yes No

BP: _____

Weight: _____ (lbs)

Please answer to the relevant questions

MENSTRUAL CYCLE

Age at first period: _____

Length of your menstrual periods: _____

When was the 1st day of your last period: _____
Yes No

Are your periods regular?

Do you have bleeding in between periods?

Do you have very heavy bleeding with clots?

Do you have painful periods?

Do you have mood changes before your period?

PREGNANCIES

How many of the following have you had:

Pregnancies: _____ Living children: _____

Vaginal deliveries: _____ Cesarean Sections: _____

Miscarriages: _____ Terminations: _____

Ectopic pregnancies: _____

SEXUAL AND REPRODUCTIVE HEALTH

Are you sexually active: Yes Not Currently Never

Are you sexually active with: Men Women Both

Which birth control method do you currently use:

Condoms Pills IUD Implant Ring None

Other: _____

Are you currently trying to conceive: Yes No

Do you have difficulty with intercourse: Yes No

Do you have history of any of the following: Yes No

Herpes (HSV) Yes No

Chlamydia/Gonorrhea Yes No

Recurrent Bacterial Vaginosis Yes No

Pelvic Inflammatory Disease Yes No

MENOPAUSE

At what age your period stopped: _____

Do you have any vaginal bleeding: Yes No

Do you use hormones replacement therapy: Yes No

Do you experience any of the following: Yes No

Hot flashes Yes No

Difficulty sleeping Yes No

Mood changes Yes No

Night sweats Yes No

Joint pain Yes No

Vaginal dryness Yes No

Pain with intercourse Yes No

SYMPTOMS/ CONCERNS

Do you experience any of the following: Yes No

Chronic pelvic pain Yes No

Urinary leakage/urgency/frequency Yes No

Vaginal irritation/discharge Yes No

MEDICAL HISTORY

Do you currently smoke: Yes No

Have you ever had: Yes No Comments (optional)

Stroke Yes No _____

Blood clots (DVT) Yes No _____

Heart disease Yes No _____

Hypertension Yes No _____

Thyroid disease Yes No _____

Liver disease Yes No _____

Cancer Yes No _____

Diabetes Yes No _____

Migraine headaches Yes No _____

Epilepsy/Seizures Yes No _____

Anemia Yes No _____

Kidney disease Yes No _____

Gallbladder disease Yes No _____

Other: _____

SURGICAL HISTORY

Please list ALL previous surgeries you have had:

MEDICATION

Please list ALL medications you are currently taking:

ALLERGIES

Please list any and all allergies:

FAMILY HISTORY

Has anyone in your family had cancer:

Yes No Relationship and age of onset

Breast cancer Yes No _____

Ovarian cancer Yes No _____

Colon cancer Yes No _____

Uterine cancer Yes No _____

Other: _____

SCREENING TEST

When was your last:

Pap smear (21y+) _____

Mammogram (40y+) _____

Colonoscopy (50y+) _____

Bone density scan (65y+) _____

Do you wish to have STD check today: Yes No