Name: ________________________________

Describe any current gynecological problems____

____

____

Date of last pelvic exam________________ performed by?______________________________________

Findings?____

Date of last pap smear________________Findings?____

Have you ever had abnormal pap smears?_________When?_____________Findings?_______________

____

Have you ever had herpes?____________venereal warts or papilloma virus?_______________________

family history of gynecological cancer?--please explain____

____

Your age at your first menstrual period___________dates of last 2 periods________________________

Usual length of cycles_____________regular or irregular?______________how?____________________

Any spotting between periods?___________usual number of days of menstrual bleeding______________

flow (number of pads or tampons per day)________________________clots?______________________

feminine hygiene sprays, deodorant pads or tampons?_______________________________________

MENSTRUAL CYCLE SYMPTOMS: please indicate all the codes for all the symptoms that apply to you

"P" for premenstrual; "D" for during the menstrual period; "A" for after the menstrual bleeding

intermittent abdominal cramps____________ constant cramps_________low back pain_______________

pressure sensations_________________headaches_________________sugar cravings______________

depression____________irritability_____________breast tenderness____________acne_____________

mood swings_______________any other symptoms?____

How severe are the symptoms?____

What treatments have you tried?____

Have you ever had vaginal yeast infections?_______treatments?______________how often?__________

Have you had any other vaginal infections or VD?__________what and when?______________________

Any undiagnosed vaginal discharges?___________describe them________________________________

Name: ________________________________

Do you use birth control? _______ What kind and how long?____

Are you satisfied with this method?____________If not, why not?____

Have you ever used birth control pills?________What kind?____

If no longer using, when and why did you stop?____

Number of pregnancies___________dates of pregnancies ____

Outcome of pregnancies ____

Describe any infertility problems ____

____

Have you ever breastfed?___________When, and for how long?____

Have you ever had breast lumps? (describe, if any)____

Ever had fibrocystic breast disease?__________Do you do breast self exams?_________How often?______

Do you ever have nipple discharge? (describe, if any)____

Have you ever had breast operations? (lump removed, cyst drained, etc)____________________________

Date of most recent mammogram________________________

Are you in menopause now?___________If so, are you still spotting or bleeding?______________________

Describe any problems____

Do you have hot flashes?___________ Other symptoms? ____

Are you post-menopausal?___________ If so, when did you go through menopause? ___________________

Have you ever had pelvic inflammatory disease?___________If so, when and how was it treated? ________

____

Describe any other problems and treatments, such as endometriosis, fibroids, ovarian cysts, etc. ________

____

____

Do you have pain in lower abdomen?___________ pressure in the vagina?_____________

pain during intercourse?_______________

Are you satisfied with your sex life?_________Any change in your sex drive or pleasure?________________

Do you have frequent urination?__________pain or burning when urinating? __________________________

Have you ever had bladder infections?___________when?____

How were they treated?____