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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
___ constipation
___ loose stool / diarrhea
___ sweating: day /night
___ feelings of heat
___ feeling cold
___ poor sleep
___ poor memory
___ tiredness
___ clumsiness
___ irritability
___ moodiness
___ depression
___ agitation
___ aggressiveness
___ Other (please describe):_____

**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? _____

_____

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**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: _____

_____

_____

_____

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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. <u>Additional Comments</u>**