Women's Health History

This information will be kept confidential.

Patient name ______________________________ **Date of Birth** ____/____/____

Menstrual history

When was your last menstrual period (LMP) ____/____/____

Has your period completely stopped? ☐ Yes ☐ No If yes, when did they stop? ____/____/____

If no longer menstruating, you may skip the rest of the questions in the menstrual history section.

Are your periods regular enough to be able to predict when you will get your next period? ☐ Yes ☐ No

How many days are between the beginning of one period to the beginning of your next menstrual period?________

Do you have any spotting between each period? ☐ Yes ☐ No

Do you have severe pain and cramping with your periods? ☐ Yes ☐ No

How many days of bleeding do you have with each cycle? ________

How many tampons or pads do you use for every day of bleeding? ________

Obstetrical history

Have you ever been pregnant? ☐ Yes ☐ No If yes, please list all your pregnancies in the list below:

Year ________ Number of Months _______ Outcome: ☐ Miscarriage ☐ Abortion ☐ Vag Delivery ☐ c/s
Sex: ☐ Female ☐ Male Weight _______ Hospital / Location: ______________________________
Any Complications? ☐ Gestational Diabetes ☐ Pre-eclampsia ☐ Other ______________________________

Year ________ Number of Months _______ Outcome: ☐ Miscarriage ☐ Abortion ☐ Vag Delivery ☐ c/s
Sex: ☐ Female ☐ Male Weight _______ Hospital / Location: ______________________________
Any Complications? ☐ Gestational Diabetes ☐ Pre-eclampsia ☐ Other ______________________________

Year ________ Number of Months _______ Outcome: ☐ Miscarriage ☐ Abortion ☐ Vag Delivery ☐ c/s
Sex: ☐ Female ☐ Male Weight _______ Hospital / Location: ______________________________
Any Complications? ☐ Gestational Diabetes ☐ Pre-eclampsia ☐ Other ______________________________

Year ________ Number of Months _______ Outcome: ☐ Miscarriage ☐ Abortion ☐ Vag Delivery ☐ c/s
Sex: ☐ Female ☐ Male Weight _______ Hospital / Location: ______________________________
Any Complications? ☐ Gestational Diabetes ☐ Pre-eclampsia ☐ Other ______________________________

Year ________ Number of Months _______ Outcome: ☐ Miscarriage ☐ Abortion ☐ Vag Delivery ☐ c/s
Sex: ☐ Female ☐ Male Weight _______ Hospital / Location: ______________________________
Any Complications? ☐ Gestational Diabetes ☐ Pre-eclampsia ☐ Other ______________________________

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Obstetrical history (conituned)

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Sex: ☐ Female ☐ Male Weight _______ Hospital / Location: ____________________
Any Complications? ☐ Gestational Diabetes ☐ Pre-eclampsia ☐ Other ____________________

Year ________ Number of Months _______ Outcome: ☐ Miscarriage ☐ Abortion ☐ Vag Delivery ☐ c/s
Sex: ☐ Female ☐ Male Weight _______ Hospital / Location: ____________________
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Year ________ Number of Months _______ Outcome: ☐ Miscarriage ☐ Abortion ☐ Vag Delivery ☐ c/s
Sex: ☐ Female ☐ Male Weight _______ Hospital / Location: ____________________
Any Complications? ☐ Gestational Diabetes ☐ Pre-eclampsia ☐ Other ____________________

Additional comments about pregnancies: ____________________

Gynecologic history

Have you ever had any abnormal pap smears? ☐ Yes ☐ No
If yes, did you have? ☐ Freezing of Cervix ☐ LEEP ☐ Cold Knife ConeProcedure
Have you had any sexually transmitted infections? ☐ Yes ☐ No
Have you ever had Pelvic Inflammatory disease (PID)? ☐ Yes ☐ No
Do you ever experience pain with intercourse? ☐ Yes ☐ No

Contraceptive history

Are you sexually active? ☐ Yes ☐ No
Do you use birth control? ☐ Yes ☐ No
If yes, what type of birth control/contraceptive do you use? ____________________
Have you ever used any other type of birth control/contraceptive? ☐ Yes ☐ No
If yes, please describe ____________________

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