Patient Name: _____ **Date:** _____

Age at which menses began: _____

Date of the first day of your last period: _____

Number of days bleeding lasts: _____

Do you have any spotting between periods? _____

Number of days in your cycle: _____

Have your cycles changed since they first began? If so, how? _____

_____

Are you currently pregnant? _____

Menstrual flow:
□Heavy □Moderate □Light □None

Color of menstrual flow:
□Light red □Red/purple □Dark red □Brown

Cramping:
□Severe □Moderate □Mild □None
□Before period □During □After period

Clotting:
□Large □Medium □Small □None
□Bright in color □Dark in color

Birth Control:
□None □IUD □Barriers □Spermicides
□Rhythm method □Condoms □Birth control pills

Previous pregnancies:
Total pregnancies: _____ Living: _____ Ectopic: _____ Induced abortions: _____ Miscarriages: _____

Have you ever had an abnormal pap smear? Yes□ No□ Date _____

Have you ever had a cervical biopsy, operation, cauterization, or conization? Yes□ No□ Date _____

Have you ever been diagnosed with HPV? Yes□ No□

Do you have chronic vaginal discharge? Yes□ No□ If yes, what color? _____

Have you gone through or are currently going through menopause? Yes□ No□ Age of menopause _____

If yes, are you currently taking any medications or hormone replacement therapy? Yes□ No□ Type _____

Please check any premenstrual syndrome symptoms that apply:
□ Fluid retention/ bloating □Cravings □Acne/ break outs □Fatigue
□Mood swings □Irritability □Back pain □Depression
□Breast tenderness □Other _____

Please check any that apply:
□Hysterectomy □Infertility □Ovaries removed □Mastitis
□Breast cysts □Brain fog □Pelvic inflammatory disease □Frequent UTI
□Vaginal discharge □PCOS □Fibroids/ cysts □Irregular periods
□Abnormal pap smear □Endometriosis □Post-menopausal bleeding □Hot flashes
□Abnormal mammogram □Nipple discharge □Recurrent yeast infection □Vaginal dryness
□Moodiness □Pain/ itching of genitalia