# Female Health History

*Please fill out to the best of your ability. If an item is not applicable, you may write **"NA"** If a question is not clear, place a **"?"** next to it, and we can go over it at your appointment. Please feel free to add any additional information.*

Age Menses started:_____

Last Menstrual period (date): _____

Number of days between periods:_____

Is your cycle normal from month to month **Yes** **No**

Number of times pregnant_____ Number of live births_____

Number of miscarriages _____ Number of abortions _____

Date of last PAP smear: _____

Any history of abnormal PAP smears? _____

How often do you perform self breast exams?_____

Have you had a mammogram? Yes No

Are you currently sexually active? Yes No

If so, are you sexually active with: Males Females Both

What is your current form of birth control (if applicable): _____

How long have you used your current form of birth control? _____

Birth control used in the past:

Type_____ Duration of use _____ Any problems?_____

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**Do you have any of the following symptoms (please indicate with a check mark):**

| Past | Currently | | Past | Currently | |
|---|---|---|---|---|---|
| | | Lumps in breast | | | Cervical cancer |
| | | Breast tenderness | | | Breast cancer |
| | | Nipple discharge | | | Uterine cancer |
| | | Pain with menses | | | Facial hair growth |
| | | Excessive menstrual flow | | | Recurrent Vaginal infections Yeast_____ other_____ |
| | | Ectopic pregnancies | | | Recurrent Urinary Tract Infections |
| | | Ovarian cysts | | | Sexually transmitted diseases (STD's) |
| | | Uterine fibroids | | | Pelvic Inflammatory Disease (PID) |