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)