Name: ____________________

Gynecological History

Age: __________ Age you began menstruating: __________
Typical days between menses: __________ Typical days of menstrual flow: __________

Please circle the following statements (or fill in the blanks) as they apply to you:

Cramps before Cramps during Low Back Pain Migraine Sciatica Nosebleeds
Cramps began on day : 1, 2, 3 Cramps lasted ______ days
On a scale of 1-10 (10 is excruciating pain) how bad were the cramps?
1 2 3 4 5 6 7 8 9 10
I missed school or work because of cramps. Yes / No If so, how many days? _______
What did you take or do to releive the pain, how much? ____________________

Day One:	Light Red/Pale	Bright Red	Dark Red	Brown	small clots	large clots
Day Two:	Light Red/Pale	Bright Red	Dark Red	Brown	small clots	large clots
Day Three:	Light Red/Pale	Bright Red	Dark Red	Brown	small clots	large clots
Last Day:	Light Red/Pale	Bright Red	Dark Red	Brown	small clots	large clots

Did you have any of the following symptoms before your period:

Moodiness	Crying Spells
Depression	Abdominal Bloating
Mania	Breast Distention /Soreness

Did you ever have:

Breast Fiboids	Abnormal Bleeding	Sexual Abuse/Rape
Endometriosis	Prolapsed Uterus	Domestic Violence
Breast Cancer	Prolapsed Bladder	Abdominal Trauma/Surgery
Cervical Cancer	Urinary Incontenence	Vaginal Trauma
Uterine Cancer	Bowel Incontenence	Sexually Transmitted Disease
Mastitis	Uterine Fibroids	list: ____________
Breast Reduction	Tubal Pregnancy	____________
Breast Augmentation	Infertility	

Pregnancy History:

	Number	Year(s) occured	Age at time
Preganicies:			
Live Births:			
Miscarriages:			
Abortions:			

Contraception History:

	Year(s) used	Age at time	Why discontinued
Contraceptive Pill			
Diaphragm			
RythymMethod			
IUD			
Implant			

Vasectomy Withdrawl Luck Other: ____________________

Birth Information:

	1st	2nd	3rd	4th	5th	6th
Age at children's birth						
Vaginal Delivery:						
C-Section:						
Epidural Used						
Episiotomy						
Complications						
Premature						
Forceps Used						
Labor Length						
Stiches Needed						
Diabetes						
Bed Rest						
Eclampsia						

Date of Last menstrual period: __________
Irregular cycle preceeding menopause: __________
Use of Hormone Replacement:
Dr. Who Prescribed HRT: ____________________

	1	2	3	4
Medication				
Date Started				
Date Ended				
Side Effects				

Other Supplements/Natural RemediesTried/Success?
____
____

Please *check the following items that you have experienced in the last six mnths or so.* Circle the two or three items which cause you the most discomfort.

- ☐ Fatigue
- ☐ Bruise Easily
- ☐ Abdominal Bloating after Eating
- ☐ Dizziness upon standing
- ☐ Loose Stools
- ☐ Diminshed Appetite
- ☐ Less Muscle Tone
- ☐ Urinary Frequency
- ☐ Urinary Incontenece
- ☐ Decreased Sexual Drive
- ☐ Cold Feet/Hands
- ☐ Low Back/Knee Pain or Weaknes
- ☐ Night Sweats
- ☐ Hot Flashes
- ☐ Dry Mouth
- ☐ Vaginal Dryness
- ☐ Hot chest and/or hands and feet
- ☐ Ringing in Ears
- ☐ Insomnia
- ☐ Restless Legs at Night
- ☐ Muscle Cramping
- ☐ Decrease in Stature
- ☐ Osteoporosis
- ☐ Thinner Skin
- ☐ Irritability
- ☐ Anger/Resentment
- ☐ Depression

Other:
____
____
____