Gynecological History

*** If menopausal please reference history of menstrual cycles ****

Age at Menarche_____
# of Live Births _____
# of Abortions_____

# of Pregnancies_____
# of Miscarriages_____

Contraceptive Type	# of Years utilized
_____	_____
_____	_____
_____	_____
_____	_____

Any side effects or negative response to contraceptive?_____

How many days is/was your last menstrual cycle? _____
How was your last menstrual cycle? Circle all that apply:

Regular	Irregular	Early	Late	Every __ months

How many days do/did you bleed? Circle:

Bleeding less than 3 days	From 3 to 5 days	Bleeding over 5 days

Quality of blood (circle all that apply):

Red / Light	Brown / Dark
Scant	Profuse

How many tampons or pads per day? _____ Clots (size)? _____

Do/Did you experience spotting?

Before period	After period	During ovulation

What type of premenstrual symptoms do/did you experience? Circle all that apply:

Pain in lower abdomen	Pain in low back	Pain radiating to genitals or legs	Cramps with downbearing sensation
Bloating	Changes in appetite	Loose stools	Constipation
Headache	Mood fluctuations	Lightheadedness	Dizziness
Cold abdomen or low back	Sleep disturbances	Sweating, night sweats	Acne

Other symptoms: _____
_____
_____

Do/Did you experience breast tenderness, breast pain, or nipple pain? _____ Any nipple discharge? _____

If so, onset and duration? _____

Any breast pain, irritability, or cramping around ovulation? _____

Do you experience abnormal vaginal discharge? _____ When (circle)? **Before** / **During** / **After** ovulation

Describe color, quantity, odor: _____

Do you experience an increase in cervical fluid around ovulation? _____

How is your libido (circle)? **Low**/ **Normal**/ **High** Does it change throughout the cycle? _____

Do you experience painful intercourse? _____

Any history of vaginal dryness, itching, or sores? _____

Any vaginal or rectal itching or history of candida overgrowth? _____

Any history of STDs/STIs? _____ Was this treated? _____

Have you ever been diagnosed with ovarian cysts, endometriosis, fibroids, or adenomyosis? _____

Have you ever had an abnormal pap smear or cervical biopsy? _____

Have you ever had any other reproductive diagnosis (approximate date)? _____

Have you ever had pelvic or gynecological surgeries (approximate date)? _____

Any hormonal evaluations or blood tests? _____ Results _____

FSH	LH	Estradiol	Progesterone
AMH	Prolactin	DHEA	Testosterone

Have you had any hormonally stimulated cycles? _____ What were the results? _____

Please include any additional information you would like to provide to us: