Patient name_____

Gynecological History Form

1. Age of first period _____ Are your cycles: _____ regular _____ irregular _____ alternates

   Any changes in your normal pattern? _____

2. First date of last menstrual period _____ Length of cycle in between menses _____

2. If menopausal, were they: _____ regular _____ irregular _____ Current post menopausal bleeding

3. Date of last pelvic exam? _____ Any abnormal findings? _____

   Have you had a pelvic sonogram? _____ If yes, when & why?_____

   Have you ever had a D & C? _____ If yes, when & why? _____

   Do you have uterine fibroids? _____ If yes, where are they located? _____

   Any history of endometriosis? _____ If yes, what are your symptoms? _____

4. Date of last Pap Smear? _____ Results? _____

   Any history of abnormal Pap Smear? _____

5. Date of last Mammogram? _____ Any abnormal findings? _____

6. Do you do monthly self-Breast exam? _____ Any current changes noted to breasts? _____

   _____

   Do you have Breast implants? _____ If yes, how long have they been in _____

7. Any recent ultrasounds performed? _____ Yes _____ No If yes, why? _____

   _____

8. Are you sexually active? _____ Yes _____ No Do you practice safe sex? _____ Yes _____ No

   Have you been tested for HIV? _____ Yes _____ No For Hepatitis? _____ Yes _____ No

9. Any history of Herpes? _____ Yes _____ No Venereal warts or Papilloma virus? _____ Yes _____ No

10. Any history of sexually transmitted diseases? _____ Yes _____ No

11. Any sexual concerns to discuss? _____ Pain with intercourse? _____Yes _____No

12. Any past tubal infections? _____

13. Any history of DES exposure? _____

14. Any unusual pelvic pain, pressure, fullness or heaviness felt? _____

15. Any unusual vaginal discharge or itching? _____

16. Please describe any infertility problems? _____

What treatments have you sought? _____

17. Is there a possibility that you may be pregnant now? _____ Yes _____ No

18. Are you trying to get pregnant? _____ Yes _____ No How long? _____

19. Current birth control method? _____ How long? _____

20. Please indicate the number of occurrences:

Abortions _____ Miscarriages _____ Pregnancies _____ Live births _____

21. Any complications with the previous occurrences? _____

22. Outcome of pregnancies, if applicable to you? _____

23. Any significant physical or emotional changes following pregnancy? _____

Menstrual Assessment

Please check **P** for premenstrual. Check **D** for during Menses. Check **A** for post menstrual.

___**P**	___**D**	___**A**	Intermittent uterine cramps	___**P**	___**D**	___**A**	Low back pains
__**P**	___**D**	___**A**	Constant uterine cramps	___**P**	___**D**	___**A**	Headaches
___**P**	___**D**	___**A**	Breast distention	___**P**	___**D**	___**A**	Sugar cravings
___**P**	___**D**	___**A**	Mood swings	___**P**	___**D**	___**A**	Fatigue
___**P**	___**D**	___**A**	Depression	___**P**	___**D**	___**A**	Acne
___**P**	___**D**	___**A**	Irritability	___**P**	___**D**	___**A**	Blood Clots
___**P**	___**D**	___**A**	Nausea	___**P**	___**D**	___**A**	Painful joints
___**P**	___**D**	___**A**	Muscle cramps	___**P**	___**D**	__**A**	Dizziness

1. How severe are your symptoms? _____

2. What treatments have you tried? _____

3. Average number of days to menstrual flow? _____

4. Your menses would be best described as: _____ Scanty _____Light _____Normal _____Heavy

5. The color is best described as: _____Clear pink _____Bright red _____Wine _____Purple ____Brown

6. Do you have any bleeding between cycles? _____

7. Do you have any vaginal discharge between cycles? _____ If so, what color? _____

8. Any feelings of cold hands and feet related to menses? _____

Post-Menopausal Assessment

1. Have you had a hysterectomy? _____Yes _____No If yes, please give age and reason_____

_____

2. Were your ovaries removed? _____Yes _____No _____Unsure

3. Have you taken HRT? _____Yes _____No _____Unsure If yes, please give the length of time taken and all medications prescribed to you for hormone replacement _____

_____

_____

4. Have you had any reactions to any of the HRT? _____

5. Have you tried any herbal formulas to balance your hormones? _____Yes _____No If so, which herbs have you taken? _____

_____

6. Have you had any reactions to any of the herbal hormonal formulas? _____

7. Do you check your hormonal levels periodically via: Labwork ___Yes ___No Saliva ___Yes ___No

Has there been any recent imbalances noted? _____

<u>Are you experiencing any of the following Menopausal signs and symptoms</u>?

_____Yes _____No Night sweats
_____ Yes _____No Hot flashes
_____ Yes _____No Day sweats
_____ Yes _____No Heart palpitations
_____ Yes _____No Poor memory
_____ Yes _____No Sleep disturbances: Difficulty in falling asleep? _____
Difficulty in staying asleep? _____
Awaken too early? _____
Insomnia? _____
_____Yes _____No Anxiety
_____Yes _____No Depression
_____Yes _____No Irritability
_____Yes _____No Anger issues
_____Yes _____No Headaches
_____Yes _____No Ringing in ears: High pitch _____ Low pitch _____ Only at night _____
_____Yes _____No Vaginal dryness
_____Yes _____No Dry & itchy skin
_____Yes _____No Changes in hair
_____Yes _____No Low back pains
_____Yes _____No Decreased libido

(Continue Menopausal Assessment)

_____Yes _____No Fatigue
_____Yes _____No Painful joints: Which ones? _____
_____Yes _____No Muscle cramps, spasms and twitching

_____Yes _____No Weight gain
_____Yes _____No Weight loss
_____Yes _____No Easy bruising
_____Yes _____No Urine incontinence
_____Yes _____No Pelvic weakness
_____Yes _____No Post-menopausal bleeding: If yes, how long?_____
_____Yes _____No Vaginal discharge
_____Yes _____No Dry & sore throat at night
_____Yes _____No Achy and hot sensations in bones at night
_____Yes _____No Osteoporosis
_____Yes _____No Hot palms and feet in PM
_____Yes _____No Dizziness
_____Yes _____No Visual disturbances
_____Yes _____No Constipation
_____Yes _____No Loose stools
_____Yes _____No Brittle nails
_____Yes _____No Cold extremities
_____Yes _____No Frequent urination
_____Yes _____No Hypertension
_____Yes _____No Loss of hearing

Are you eating regular meals? _____ Do you include protein with each meal? _____

Are you skipping meals? _____ If so, why? _____

What time of day is your last meal? _____ How many hours is that before bedtime? _____

Is there anything else that you wish to share with me regarding your gynecological history? _____

_____

_____

_____

_____

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