

FEMALE PATIENT SPECIFIC INFORMATION

Sexual history:

- Experience pain during intercourse
 Bleeding with intercourse
 Headache soon after orgasm
 High libido
 Low libido

Frequency of intercourse: _____ per week/month (circle one).

Pregnancy history:

of pregnancies: _____ Term births: _____ Premature births: _____ Miscarriages: _____ Elective abortions: _____ Stillbirth: _____

DATE	BIRTH T = TERM P = PREMATURE	MISCARRIAGE	ELECTIVE ABORTION	ECTOPIC PREGNANCY	INFERTILITY TREATMENT	C-SECTION	OTHER COMPLICATIONS	IS CURRENT PARTNER THE FATHER?

Contraceptive use:

TYPE: OCE/DEP/NUVARING/DIAPHRAGM/ETC.	FROM WHEN TO WHEN?	REASON FOR DISCONTINUING USE

Gynecology/Infections:

- Pelvic infection
 Vaginal dryness
 Gonorrhea
 Ovarian cysts
 Chlamydia
 Colitis/enteritis
 Syphilis
 Toxoplasmosis
 Endometriosis
 Uterine fibroids/myomas
 Mycoplasma
 Cytomegalovirus (CVS)
 Pelvic adhesions
 Abnormal uterus shape
 Ureaplasma
 Tuberculosis
 Cervicitis
 Recurrent vaginitis
 Genital warts/condyloma
 Trichomonas
 Genital herpes
 Abnormal pap smears
 Cryo (freezing) or surgery of the cervix
 Other infections/problems: _____

Do you have, or have you ever experienced:

- Hot flashes Increased facial/body hair Breast discharge
 Vaginal discharge Weight gain > 10 pounds Weight loss > 10 pounds

Date of last pap smear: (mm/dd/yyyy) _____ Date of last mammogram: (mm/dd/yyyy) _____

Menstrual history:

Age of first period: _____ Are your periods regular? Yes No

of days from onset to onset: _____ Duration of periods (days): _____

Do you bleed between cycles? Yes No

PMS Symptoms:

	None	Before menstruation	After menstruation	At mid cycle
Emotional	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breasts swelling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breast tenderness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Back pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Facial acne	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Acne on back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Acne on body	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal bloating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pelvic pain/cramps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe