### Menstrual History

**Date of last menstrual period:**

**Is your bleeding:**
- [ ] Light
- [ ] Moderate
- [ ] Heavy

**How many days does the bleeding last?**

### Menstrual Symptoms:

- [ ] Cramps
- [ ] Severe Pain
- [ ] Bloating
- [ ] Breast Tenderness
- [ ] Severe Emotional Change
- [ ] Nausea

### Gynecological History

**Approximate date of last gynecological exam?**

**Did you have a pap smear at that visit?**
- [ ] YES
- [ ] NO

**Did you have a breast exam at your last gynecological visit?**
- [ ] YES
- [ ] NO

**Have you ever had any of the following? (please check all that apply)**

- [ ] Abnormal Pap
- [ ] Positive HPV test
- [ ] Yeast Infection
- [ ] Genital Herpes
- [ ] Gonorrhea
- [ ] Genital Warts
- [ ] Chlamydia

### Sexual History

**Are you sexually active?**
- [ ] YES
- [ ] NO

**Do you experience pain or other difficulties with sexual activities?**
- [ ] YES
- [ ] NO

**If yes, specify:**

**Have you ever been hurt or frightened during sex?**
- [ ] YES
- [ ] NO

**If yes, specify:**

### Pregnancy History

**Have you ever been pregnant?**
- [ ] YES
- [ ] NO

**Have you ever had an abortion?**
- [ ] YES
- [ ] NO

**How many pregnancies have you had?**

**Any complications with previous pregnancies?**
- [ ] YES
- [ ] NO

**If yes, please specify:**

**If yes, please specify:**
### Personal History

<table>
<thead>
<tr>
<th>Smoker:</th>
<th>None</th>
<th>Past</th>
<th>Current</th>
<th>If current, amount per day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol:</td>
<td>None</td>
<td>Past</td>
<td>Current</td>
<td>If current, amount per day</td>
</tr>
<tr>
<td>Recreational Drugs:</td>
<td>None</td>
<td>Past</td>
<td>Current</td>
<td>If current, amount per day</td>
</tr>
</tbody>
</table>

### Personal and Family History

<table>
<thead>
<tr>
<th>Cancer</th>
<th>Self</th>
<th>Family</th>
<th>Liver Disease</th>
<th>Self</th>
<th>Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart Disease</td>
<td>Self</td>
<td>Family</td>
<td>Gallbladder Disease</td>
<td>Self</td>
<td>Family</td>
</tr>
<tr>
<td>Stroke</td>
<td>Self</td>
<td>Family</td>
<td>Bleeding/Clotting</td>
<td>Self</td>
<td>Family</td>
</tr>
<tr>
<td>High Blood Pressure</td>
<td>Self</td>
<td>Family</td>
<td>Thyroid Problems</td>
<td>Self</td>
<td>Family</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Self</td>
<td>Family</td>
<td>Elevated Cholesterol</td>
<td>Self</td>
<td>Family</td>
</tr>
<tr>
<td>Blood Clot</td>
<td>Self</td>
<td>Family</td>
<td>Depression</td>
<td>Self</td>
<td>Family</td>
</tr>
<tr>
<td>Seizures</td>
<td>Self</td>
<td>Family</td>
<td>Allergies</td>
<td>Self</td>
<td>Family</td>
</tr>
<tr>
<td>Migraines</td>
<td>Self</td>
<td>Family</td>
<td>Other: __________</td>
<td>Self</td>
<td>Family</td>
</tr>
<tr>
<td>Kidney Disease</td>
<td>Self</td>
<td>Family</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Contraceptive History

Please include all methods of birth control you are using or have used in the past. Check all that apply.

- [ ] Condom
- [ ] Birth Control Pills
- [ ] Depo Provera
- [ ] Patch
- [ ] Lunelle
- [ ] IUD
- [ ] Diaphragm
- [ ] Cervical Cap
- [ ] Spermicide
- [ ] Withdrawal
- [ ] Other: __________

### Surgical History

Please list any and all surgeries you have had done

<table>
<thead>
<tr>
<th>Surgery</th>
<th>Date/Year Performed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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