Gynecology

Age of first menses?: _____ Date of last menstrual period?: _____ Duration of flow?: _____

Length of cycle: _____ Blood clots?: yes no When?: _____

Color of menstrual blood?: pale bright red dark red brown Other?: _____

Texture of menstrual blood?: thick thin watery regular to you

Pain?: yes no when: _____ Irregular periods (describe)?: _____

PMS (describe)?: _____

Current method of contraception?: _____ Past method of contraception?: _____

Are you currently pregnant? yes no Number of pregnancies?: _____ Number of live births?: _____

Number of miscarriages?: _____ Number of abortions?: _____ Number of premature births?: _____

Breasts (lumps, cysts, tenderness, discharge, etc.)?: _____

Urinary tract infections?: yes no How frequent?: _____

Vaginal infections/discharge?: yes no How frequent?: _____

Describe color/consistency: _____

Pain/itching of genitalia?: yes no Describe: _____

Date of last Pap smear?: _____ Pap smear?: normal abnormal Findings?: _____

Uterine fibroids?: yes no Endometriosis?: yes no Other?: _____

Menopause (date of onset)?: _____ Symptoms?: _____

_____

Any bleeding since?: yes no When?: _____

Are you currently on Hormone Replacement Therapy (HRT)? yes no Dose?: _____

How long have you been on HRT?: _____ Any side effects?: _____

_____

Other gynecological information of note?: _____

_____

_____

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