WOMEN'S HEALTH HISTORY FORM

PATIENT INFORMATION

Last Name:		First Name:	
Referring Physician:		Diagnosis:	
D.O.B.:	Age:	Height:	Weight:

GYN HISTORY

Age at first menstrual period: _____ Last Menstrual Cycle: _____

Do you have regular menstrual periods: ☐ Yes ☐ No Length of period in days: _____

Amount of flow: ☐ Light ☐ Moderate ☐ Heavy

Do you have or have you had any of the following?

☐ Painful Intercourse	☐ Cysts	☐ Menstrual Pain/Dysfunction
☐ Fibroids	☐ Urinary Tract Infections	☐ Urge Incontinence
☐ Uterine Prolapse	☐ Endometriosis	☐ Stress Incontinence
☐ Pelvic Inflammatory Disease	☐ Pelvic Pain	☐ Fecal Incontinence
☐ Coccyx pain	☐ Breast Cancer	☐ Menopause – Age began:

Are you pregnant? _____ Estimated due date:_____

PREGNANCY HISTORY

Date of Delivery	Delivery Type: Vaginal or C-Section.	Pre or Full term Miscarriage Abortion	Weeks Pregnant	Weight	Sex	Hours in labor	Complications

Explain any complications during pregnancy, labor and delivery or postpartum (if any) _____

_____

_____

WOMEN'S HEALTH ISSUES

Current weight? _____Are you satisfied with your current weight? _____

Has there been any change to your weight in the last 6 months? _____

Patient/Guardian Signature: _____ Date:_____

(If the patient is under 18, or is 18 and still in high school, the parent or guardian must sign.)