



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?

<input type="checkbox"/> Painful Intercourse	<input type="checkbox"/> Cysts	<input type="checkbox"/> Menstrual Pain/Dysfunction
<input type="checkbox"/> Fibroids	<input type="checkbox"/> Urinary Tract Infections	<input type="checkbox"/> Urge Incontinence
<input type="checkbox"/> Uterine Prolapse	<input type="checkbox"/> Endometriosis	<input type="checkbox"/> Stress Incontinence
<input type="checkbox"/> Pelvic Inflammatory Disease	<input type="checkbox"/> Pelvic Pain	<input type="checkbox"/> Fecal Incontinence
<input type="checkbox"/> Coccyx pain	<input type="checkbox"/> Breast Cancer	<input type="checkbox"/> 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, the parent or guardian must sign.)