GYNECOLOGY

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

Blood clots: yesnowhen: _____ Length of cycle _____

Color of menstrual blood:palebright reddark redbrown other _____

Texture of menstrual blood: thickthinwaterynormal

Pain: yesnowhen: _____

Irregular periods (describe): _____

PMS (please describe): _____

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

Are you currently pregnant?yesno

Number of pregnancies:

Number of live births:

Number of miscarriages:

Number of abortions:

Any premature births:

Breast (lumps, cysts, tenderness, etc.): _____

Urinary tract infections: _____ How frequent? _____

Vaginal infections/ discharges (describe color): _____

Pain/itching of genitalia: _____

Pap smear:normalabnormalDate of last Pap smear: _____

Uterine fibroids: _____ Endometriosis: _____ Other: _____

Menopause (date of onset): _____ Symptoms: _____

_____

Any bleeding since? _____

Are you currently on Hormone Replacement Therapy (HRT)? yesnoDose: _____

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

Other: _____

_____

_____

_____