**FEMALE HEALTH HISTORY**

**This work needs to be modified or rescheduled if you are pregnant, wear an IUD, have had surgery within the last 6 weeks, or have a fever. Please advise.**

**Menstrual History:**

**Age of Menarche(first menses)\_\_\_\_\_\_\_\_\_\_\_\_\_What was this like for you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you currently have a menstrual cycle? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ If so, what was the date of last menstrual cycle: \_\_\_\_\_\_\_\_\_\_ Length between cycles:\_\_\_\_\_\_\_\_\_\_\_\_\_ How many days do you menstruate?\_\_\_\_\_\_\_**

**Are (or were) your cycles regular/irregular? How many days between cycles? How many days of menses? Color of menstrual fluid? Clots? Heavy? Light?**

**Is there pain associated with menses (cramping, headaches, nausea, PMS, etc.)? Describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Have you had episodes of amenorrhea (no menses)? Y N When & how long?\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Have you had an irregular pap smear? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Have you had any uterine treatment such as CONE, DNC, etc.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Method of Contraception (circle) and length of time used: pills patch diaphragm injection condoms IUD abstinence natural birth control other:\_\_\_\_\_\_\_\_\_\_\_\_**

**Describe your cycle, including physical and emotional observations throughout the cycle.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please mark P for past or C for currently as appropriate:**

**Painful menses Irregular cycles (early? late?)**

**Dark thick blood at *beginning* of cycle Dark thick blood at the *end* of cycle**

**Headache/migraine with menses Dizziness with menses**

**PMS/depression with or before menses Excessive bleeding (>one pad/hour)**

**Failure to ovulate Painful ovulation**

**Low back ache Constipation/diarrhea at bleed**

**Bloating/water retention with menses PMS**

**Other:**

**General Regenerative Health: Please mark P for past or C for currently as appropriate:**

**Painful menses Irregular cycles (early? late?)**

**Dark thick blood at *beginning* of cycle Dark thick blood at the *end* of cycle**

**Headache/migraine with menses Dizziness with menses**

**PMS/depression with or before menses Excessive bleeding (>one pad/hour)**

**Failure to ovulate Painful ovulation**

**Varicose veins Tired weak legs**

**Numb legs and feet when standing Sore heels when walking**

**Low back ache Painful intercourse**

**Constipation Endometriosis**

**Uterine infections Uterine polyps**

**Hemorrhoids (size & location) Vaginal Discharge (describe:**

**Bladder infections/incontinence Chronic miscarriage**

**Weak newborn infants Premature deliveries**

**Incompetent cervix Spotting with pregnancy**

**Pelvic inflammation Sexually transmitted disease (date/type):**

**Dry vagina Difficult menopause**

**Cancer Cysts (Breast? Ovarian? Uterine?)**

**Vaginitis Difficult pregnancy**

**Bloating/water retention with menses Uterine infections**

**Painful Intercourse Vaginal Discharge (describe:**

**Varicose veins Numb legs and feet when standing**

**Sore heels when walking Fibroids**

**Maternal Family History (circle): infertility fibroids endometriosis cancer (type):\_\_\_\_\_\_\_\_\_ menstrual problems menopausal symptom(s) (type):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PMS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Rate your interest in sex: High Moderate Low None Do you experience pain upon intercourse? Y N**

**Do you have or ever had difficulty experiencing orgasms? Y N Known Reason?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Have you experienced a history of: rape trauma incest emotional abuse If so, when?\_\_\_\_\_\_\_\_\_\_\_**

**Did you undergo counseling for this? Y N What was this like for you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Regenerative History:**

**Pregnancies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Termination(s):\_\_\_\_\_\_\_\_\_ Date(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Miscarriage(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**If you have experienced pregnancy, what was your experience like?**

**How was your experience of labor and delivery?**

**What was your experience of postpartum?**

**Did you nurse? Y N How long?\_\_\_\_\_\_\_\_\_\_\_\_**

**Any complications:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please mark P for past or C for currently as appropriate:**

Chronic miscarriage Difficult pregnancy

Weak newborn infants Premature deliveries

Incompetent cervix Spotting with pregnancy

**Are you under treatment for infertility? Y N Describe current treatment to date (IUI, IVF, etc):**

**Menopausal History: Age at Menopause: \_\_\_\_\_\_\_\_ Did you experience any symptoms? Describe:**

**Menopause Please mark P for past or C for currently as appropriate. These symptoms may or may not have been related.**

**Hot flashes Mood Swings Vaginal Discharge Dry Vagina**

**Insomnia Depression Anxiety Irritability**

**Fatigue Spotting Flooding Irregular menses**

**Memory loss Painful intercourse Increased/decreased libido Disturbed sleep**

**Clotting**

**Other symptoms not listed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Are you currently experiencing any symptoms? (Describe) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**How long? \_\_\_\_\_\_Are they getting worse?\_\_\_\_\_ Better?\_\_\_\_\_\_ Same?\_\_\_\_\_\_\_ If they were in the past, how long did they last? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Age of mother at menopause? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Are you on, or have you ever been on, hormone replacement therapy? Y N**

**If so, how long?\_\_\_\_\_\_\_\_\_\_\_ Name and dose \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Oral or topical?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_If stopped, reason? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Other medications/herbal remedies taken for symptoms?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Concerns/experience \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Additional comments:**