Gynecology. Women's Health. Date: _____

Name: _____ Age: _____ Height: _____ Weight: _____

Reason for Visit: _____

_____

_____

Gynecological and Obstetrical History: Last Pap / Gynecological exam: _____

Vaginal Delivery/ Cesarean section/ pregnancy loss or termination (circle one)	Year	Issues/ concerns (if relevant or wish to discuss) Example: fertility concerns, complications, etc.
V - C/S - PLT		
V - C/S - PLT		
V - C/S - PLT		
V - C/S - PLT		

Current menstrual cycle: Date of the first day of the last menstrual period (LMP): _____

Cycle: **regular** (every _____ days) / **irregular** (every _____ to _____ days) / **cycle stopped/ Menopause**? _____

Flow: How long? _____days: spotting / light ___ d, medium___ d, heavy____d, continuous flow/clots _____days

pads/ tampons used on heaviest day _____ Menstrual pain/ cramps? _____before/during/after

Pelvic / vaginal pain? _____ Only during intercourse? _____

Current contraception: condoms/ Pill (name)_____ /IUD (copper/hormonal), vasectomy, none

Menopausal symptoms? Have you tried any treatment for these previously? _____

Vaginal dryness	Pain with intercourse	Bladder incontinence	Vaginal pressure
Hot flashes: /day	Night sweats	Sleep disturbance	Memory/ concentration

Smoker? Y / N / Quit_____ Alcohol/ drugs? _____ Family Med. History: _____

Other concerns? _____ _____

Medical Conditions/ History:		Previous Surgeries:
		Current Medications:
Allergies:		