Women's Health History:

Date last	period began:				
Date prio	r period began:				
Age of fin	rst period:				
Are you s	sexually active?	Do yo	ou practice safe sex?	_	
Are you p	oregnant? (if you	are currently pregr	ant, please answer Pregnancy Q	uestions be	low)
Are you t	rying to get pregnant?	How	long?	_(see Ferti	lity Form)
Current b	oirth control method:	How	long?		
Normally	(not on pills), the number of	days from the sta	rt of one period to the start of the	e next:	
Average	number of days in flow:				
Color (no	ormal, bright red, pale, brown	, rust, dark, purple	e, other):	_	
Amount o	of flow: Heavy Mod	lerate 🗆 Light	□ Pain/cramps (location, dull,	sharp, othe	r):
Cramps d	luring ovulation:	Clots (large, sm	all, black, purple, red, other):		
Do you e	xperience any of the followir	ng pre-menstrual sy	ymptoms?		
□ Nausea	□ Vomiting □ Water Re	tention Breast	Swelling	□ Headach	es Migraines
□ Breast	Tenderness Depression	□ Irritability	□ Anxiety □ Other Emotions	i:	
Do you h	ave any sexual concerns to d	iscuss?			
_					
How wou	ıld you describe your sexual	energy?			
Do you d	ouche regularly? With what)			
			ryness/itching?		
			Tyness/Iteming:		
Do you n	ave excessive facial fiall:				-
Urin	ation:		Urgent		Abnormal Pap Smears
	□ Normal color□ Dark yellow		Frequent Incontinence		Endometriosis Uterine Fibroids
	☐ Clear	Gynecol		ō	PCOS (Polycystic ovarian
	□ Reddish □ Cloudy		<25 day cycle		syndrome) POF (Premature ovarian
	□ Scanty		>35 day cycle Irregular Periods		failure)
	□ Profuse□ Strong odor		Spotting Between Periods		PID (Pelvic inflammatory disease)
	☐ Burning		Loose bowel movements at onset of menses		Any pelvic abnormalities
	Painful		Regular yeast infections		Other:
	□ Difficult		UTI or Bladder Infections		
Pregnan	cies (including miscarriages	s and abortions):			
Dates	Sex	Weight	Problems		Fertility Treatment

If you are currently pregnant, please answer the following o	questions:
How many weeks pregnant are you?	What is your due date?
When was your last appointment with your doctor/midwife? _	Blood Pressure:
What is your doctor/midwife's name?	
Address:	
Phone number:	
Are you using a doula? Doula's Name	
Where are you delivering?	
What prenatal classes are you taking or planning on taking?	
Major symptoms (please check all that apply):	
□ Nausea □ Vomiting □ Fatigue □ Water Retention	□ Body Aches and Pains , where?
□ Heartburn □ Constipation □ Hemorrhoids □ Anxiety	□ Other:
Menopause	
Age of menopause (if applicable):	
Major symptoms (please check all that apply):	
□ Fatigue □ Hot Flashes □ Night Sweats □ Weight Gain	n 🗆 Anxiety 🗆 Insomnia 🗆 Vaginal Dryness 🗆 Low
Libido Other:	
Notes/Comments	