PATIENT NAME_____DATE_____

My last menstrual period began on:_____

*** IF YOU HAVE STOPPED HAVING MENSTRUAL PERIODS ANSWER THE FOLLOWING QUESTIONS***

1. My uterus was removed. YES NO
2. I have been through menopause. YES NO
3. Do you take female hormone pills? YES NO

*** IF YOU ARE STILL MENSTRUATING ,ANSWER THE FOLLOWING QUESTION***

1. I am currently using birth control pills YES NO
2. I am currently using an IUD YES NO
3. I am pregnant YES NO
4. My doctor did a pregnancy test on:_____
5. If you had a pregnancy test was it blood or urine?_____
6. The results of the test was POSITIVE NEGATIVE

*** ALL PATIENTS ANSWER THE FOLLOWING QUESTION***

1. I have or recently had vaginal bleeding YES NO
2. I have pelvic pain on my RIGHT LEFT BOTH SIDES
3. I have cramping YES NO
4. Other symptoms_____
5. How many children do you have_____
6. How many pregnancies have you had_____

SURGICAL HISTORY

1. I have had surgery on my female organs YES NO
2. My uterus was removed YES NO
3. My ovary was removed YES NO

   Which ovary RIGHT LEFT BOTH

4. I have been treated for cancer YES NO
5. If so, when_____ What type_____
6. What treatment if any