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FEMALE MEDICAL HISTORY

(For women only)

OBSTETRICS HISTORY

Check box if yes, and provide number of pregnancies and/or occurrences of conditions

- ❑ Pregnancies_____ ❑ Caesarean _____ ❑ Vaginal deliveries_____
- ❑ Miscarriage_____ ❑ Abortion _____ ❑ Living Children_____
- ❑ Post partum depression__ ❑ Toxemia _____ ❑ Gestational diabetes_____

GYNECOLOGICAL HISTORY

Age at first menses?_____ Frequency:_____Length:_____

Painful: Yes_____ No_____ Clotting: Yes_____No_____

Date of last menstrual period:____/____/_____

Do you currently use contraception? Yes_ _ No_____If yes, what please indicate which form:

Non-hormonal

- ❑ Condom
- ❑ Diaphragm
- ❑ IUD
- ❑ Partner vasectomy
- ❑ Other (non-hormonal-please describe)_____

Hormonal

- ❑ Birth control pills
- ❑ Patch
- ❑ Nuva Ring
- ❑ Other (please describe)_____

Even if you are *not* currently using conception, but have used hormonal birth control in the past, please indicate which type and for how long._____

Do you experience breast tenderness, water retention, or irritability (PMS) symptoms in the second half of your cycle? Yes_____ No _____

Please advise of any other symptoms that you feel are significant._____

_____

_____

_____

Are you menopausal? Yes_____ No_____If yes, age of menopause_____

Do you currently take hormone replacement? Yes____No____If yes, what type and for how long?_____

❑ Estrogen ❑ Ogen ❑ Estrace ❑ Premarin ❑ Progesterone ❑ Provera

❑ Other_____

DIAGNOSTIC TESTING

Last PAP test:_____/___/_____Normal:_____Abnormal_____

Last Mammogram_____/_____/_____Breast biopsy? Date:_____/_____/_____

Date of last bone densitiy_____/_____/_____Results: High_____Low_____Within normal range_____