

Age of first menses: \_\_\_\_\_ Date of last menstrual period: \_\_\_\_\_ Duration of flow: \_\_\_\_\_  
 Blood clots: yes no \_\_\_\_\_ when: \_\_\_\_\_ Usual length of cycle: \_\_\_\_\_  
 Color of menstrual blood: (please circle) pale bright red dark red brown other \_\_\_\_\_  
 Texture of menstrual blood: thick thin watery normal \_\_\_\_\_  
 Pain: yes no \_\_\_\_\_ when: \_\_\_\_\_  
 Irregular periods (describe): \_\_\_\_\_  
 PMS: moodiness breast tenderness bloating constipation other \_\_\_\_\_  
 Current method(s) of contraception: \_\_\_\_\_ Past method(s) of contraception: \_\_\_\_\_  
 Are you currently pregnant? yes no \_\_\_\_\_ Are you trying to get pregnant? yes no \_\_\_\_\_  
 Number of pregnancies: \_\_\_\_\_ Number of live births: \_\_\_\_\_  
 Number of miscarriages: \_\_\_\_\_ Number of abortions: \_\_\_\_\_ Any premature births: \_\_\_\_\_  
 Breast (lumps, cysts, tenderness, etc.): \_\_\_\_\_  
 Urinary tract infections: \_\_\_\_\_ How frequent? \_\_\_\_\_  
 Vaginal infections/ discharges (describe color and/or smell): \_\_\_\_\_  
 Pain/itching of genitalia: \_\_\_\_\_  
 Date of last Pap smear: \_\_\_\_\_ Pap smear: normal abnormal \_\_\_\_\_  
 Date of last mammogram: \_\_\_\_\_ Mammogram; normal abnormal \_\_\_\_\_  
 Uterine fibroids: \_\_\_\_\_ Endometriosis: \_\_\_\_\_ Other: \_\_\_\_\_  
 Menopause (date of onset): \_\_\_\_\_ Symptoms: \_\_\_\_\_ Any bleeding since? \_\_\_\_\_  
 Are you currently on Hormone Replacement Therapy (HRT)? yes no Dose: \_\_\_\_\_  
 How long have you been on HRT? \_\_\_\_\_ Any side effects? \_\_\_\_\_  
 Name and contact information of your current gynecologist: \_\_\_\_\_