

## WOMEN'S HEALTH MEDICAL FORM

### Medical History

(Please circle letters for: **N**ever, **O**nce, **S**ometimes, **F**requent, **A**lways)

Bladder Infection	N-O-S-F-A	Interstitial Cystitis	N-O-S-F-A
Kidney Infection	N-O-S-F-A	Kidney Stones	N-O-S-F-A
Pelvic or Abdominal Adhesions	N-O-S-F-A	Hormonal Problems	N-O-S-F-A
Pelvic Pain	N-O-S-F-A	Abdominal Pain	N-O-S-F-A
Cysts	N-O-S-F-A	Digestive Problems	N-O-S-F-A
Intestinal Problems	N-O-S-F-A	Hemorrhoids	N-O-S-F-A
Chronic Fatigue	N-O-S-F-A	Uterine Fibroids	N-O-S-F-A
Incontinence	N-O-S-F-A	Endometriosis	N-O-S-F-A
Vaginal Infection	N-O-S-F-A	Constipation	N-O-S-F-A
Pelvic Inflammatory Disease (PID)	N-O-S-F-A	Neurological Disorder	Yes/No
Painful Intercourse	N-O-S-F-A	Polyps	N-O-S-F-A
STD or herpes	N-O-S-F-A	Vaginal Dryness	N-O-S-F-A

Please provide any additional information: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### Surgical History

(Please provide the approximate date)

Surgery	Y e s	N o	Surgery	Y e s	N o
Pelvic Surgery			Adhesion Removal		
Fibroids Removed			Abdominal Surgery		
Laparoscopy			Laparotomy (open surgery)		
Appendectomy			Episiotomy		
Surgery to the Cervix			Hysterectomy (total/partial)		
Bladder Repair			Other:		

### Dietary/Lifestyle History

Do you drink alcohol? ..... Yes / No  
If yes, how many drinks do you have a day? ..... Week? \_\_\_\_\_  
Do you smoke cigarettes? ..... Yes / No  
If yes, how many cigarettes do you smoke daily? .....  
How many cups of caffeinated coffee do you drink daily? 0, 1-2, 3-4, 5-6, >6  
How many cups of decaffeinated coffee do you drink daily? 0, 1-2, 3-4, 5-6, >6  
How many additional caffeinated drinks do you drink daily? 0, 1-2, 3-4, 5-6, >6  
How many hours per week do you exercise? 0, 1-2, 3-4, 5-6, Over 6  
What exercises? \_\_\_\_\_

### Menstruation and Pregnancy History

Date of your most recent pelvic exam .....  
What form of birth control do you use? .....  
Date of your last period .....  
\_\_\_\_\_

#### Menstruation History:

Age when you had your first menstrual cycle? .....  
How often do you have a period (in days)? ..... every \_\_\_\_ days  
On average, how long does your period last (in days)? .....  
Do you ever experience pain with your periods? ..... Yes / No  
If yes, do you need medication? ..... Yes / No  
What other symptoms do you experience with your period? \_\_\_\_\_  
\_\_\_\_\_

#### Pregnancy History:

How many pregnancies have you had? .....  
How many were full term? .....  
How many tubal pregnancies (ectopics)? .....  
Have you had any miscarriages? ..... Yes / No  
Have you had any abortions? ..... Yes / No  
Have you ever been told that you are infertile? ..... Yes / No  
Are you undergoing any treatment for infertility? ..... Yes / No

#### Labor & Delivery History:

Please list any complications with labor & delivery \_\_\_\_\_  
\_\_\_\_\_

Did you have an episiotomy? ..... Yes / No  
Did you have a C-section? ..... Yes / No