

**MENSTRUAL HISTORY**

When was your last monthly period? \_\_\_\_\_

Are you past your menopause, or have you had a hysterectomy? \_\_\_\_\_

If Yes: Have you noticed any vaginal bleeding since? \_\_\_\_\_

If No: How old were you when your periods started? \_\_\_\_\_

Have you had any abnormal bleeding? \_\_\_\_\_

When? \_\_\_\_\_ How long? \_\_\_\_\_

How many days pass between the first day of each period? \_\_\_\_\_

How long do your periods last? \_\_\_\_\_

**GYNECOLOGICAL HISTORY**

When was your last Pap Smear? \_\_\_\_\_ Where? \_\_\_\_\_

Have you had an abnormal Pap Smear before? \_\_\_\_\_

PLEASE CHECK NO OR YES TO EACH OF THE FOLLOWING:

	NO	YES
Do you examine your breasts at least once a month?	<input type="checkbox"/>	<input type="checkbox"/>
Have you noticed any discharge from your breasts?	<input type="checkbox"/>	<input type="checkbox"/>
Have you noticed any lumps in your breasts?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had recurrent bladder infections?	<input type="checkbox"/>	<input type="checkbox"/>
Are you bothered by frequent or painful urination?	<input type="checkbox"/>	<input type="checkbox"/>
Do you lose urine when you sneeze or cough?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a vaginal discharge?	<input type="checkbox"/>	<input type="checkbox"/>
Is it burning, itchy, irritating, smelly, discolored?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had a pelvic infection?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had a venereal disease?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have vaginal dryness?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have pelvic pain?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a sexual problem that you wish to discuss with the doctor?	<input type="checkbox"/>	<input type="checkbox"/>

Please indicate your present method of birth control.  
\_\_\_\_\_ None or \_\_\_\_\_

Have you ever had any complications with any type of birth control?

**YOUR FAMILY HISTORY**

Is your father living? \_\_\_\_\_ Age if living \_\_\_\_\_ Age at death \_\_\_\_\_

Did or does he have a chronic illness? \_\_\_\_\_ What? \_\_\_\_\_

Is your mother living? \_\_\_\_\_ Age if living \_\_\_\_\_ Age at death \_\_\_\_\_

Did or does she have a chronic illness? \_\_\_\_\_ What? \_\_\_\_\_

How many brothers do you have? \_\_\_\_\_ How many sisters do you have? \_\_\_\_\_

Do any of them have a chronic illness? \_\_\_\_\_ Who? \_\_\_\_\_

What? \_\_\_\_\_

Are any of them deceased? \_\_\_\_\_ Cause \_\_\_\_\_

Is there a family history of breast cancer? \_\_\_\_\_ Diabetes? \_\_\_\_\_