**Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_\_ Marital Status \_\_\_\_ Date \_\_\_\_\_\_**

**Menstrual History**

If menopausal, at what age did your periods stop? \_\_\_\_\_\_\_

Number of days between first day of one and first day of next period? \_\_\_\_\_\_\_\_\_

Length of period? \_\_\_\_\_\_\_\_\_\_\_\_ Regular or Irregular \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Would you call your periods ( ) light ( ) medium ( ) heavy ( ) clots

When was the first day of your last menstrual period? \_\_\_\_\_\_\_\_\_ Do you have cramps?\_\_\_\_\_

Was it a normal period? \_\_\_\_\_\_\_ If not, when was the last normal one? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Would you like information on a simple, safe procedure performed in our office that can significantly reduce or eliminate your monthly periods/cramps? \_\_ Y \_\_ N

**Contraception– (If premenopausal)**

What is your current form of birth control?

Abstinence Birth Control pill Hysterectomy IUD Menopause Tubal ligation Vasectomy Nuvaring Patch Depoprovera Rhythm Condoms Nexplanon

How long have you been using your current form of birth control? (please check one)

\_\_ 2 yrs or less \_\_ 3-5 yrs \_\_ 6-10 yrs \_\_ over 10 yrs

When are you planning to have another child? (please check one)

\_\_ within 1-2 yrs \_\_ within 5-10 yrs \_\_ my family is complete

**Review of Symptoms: (Circle current symptoms)**

**GENERAL**– Fatigue Fever Weight gain Weight loss

**CARDIOVASCULAR**– Palpitations Chest pain

**PULMONARY**– Cough Shortness of breath

**GASTROINTESTINAL**– Bloating Constipation Diarrhea Hemorrhoids Bloody stools Nausea

**URINARY**– Pain with urination Blood in urine Frequency UTI’s Incontinence

**GENITAL**- Irregular periods Painful intercourse History of sexual abuse Vaginal discharge Vaginal itching

**MUSCULOSKELETAL**- Back pain Joint pain

**Breast**- Perform self breast exams-Regularly/Irregularly/Never Masses Tenderness Nipple discharge

**SKIN**- Rash Warts

**NEUROLOGICAL**- Dizziness Headache

**BLOOD/LYMPHATIC**- Easy bruising Bleeding easily History of blood transfusion Enlarged lymph nodes

**ENDOCRINE**- Hair loss Temperature intolerance Excessive hair growth

**ALLERGIES**- Seasonal allergies

**PSYCHIATRIC**- Anxiety Depression PMS Insomnia

Smoking \_\_\_cigs/day Vaping\_\_\_ Alcohol \_\_drinks/wk Caffeine \_\_\_servings/day Illicit Drugs

Do you feel safe in your current relationship?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have an Advance Directive?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is blood transfusion acceptable in an emergency?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_