Patient Name:_____Date:_____

Female Health History Form (*Page 1*):

Please answer the following questions as they relate to you, past or present:

1. How long ago did your menstrual period start?_____.
2. Are you currently pregnant or breastfeeding? ☐No. ☐Yes.
3. Have you noticed any skipped menstrual cycles? ☐No. ☐Yes.
4. Has your menstrual period recently had a shortened length? ☐No. ☐Yes. If yes, how long?_____.
5. Has your menstrual period recently had a prolonged length? ☐No. ☐Yes. If yes, how long?_____.
6. Are you experiencing pain and/or cramping during your periods? ☐No. ☐Yes.
7. Does the pain begin on the first day of your menses? ☐No. ☐Yes.
8. Is your menstrual blood flow scanty or space? ☐No. ☐Yes.
9. Is your menstrual blood flow heavy? ☐No. ☐Yes.
10. Are your menstrual periods occurring irregularly? ☐No. ☐Yes.
11. Do you experience breast pain & swelling during your menses? ☐No. ☐Yes.
12. Have you noticed any breast lumps? ☐No. ☐Yes. If yes, are they associated with your menses? ☐No. ☐Yes.
13. Are you irritable or depressed during your menses? ☐No. ☐Yes.
14. Do you have acne breakouts during your menstrual cycle? ☐No. ☐Yes.
15. Is your menses so painful that it interferes with normal activities? ☐No. ☐Yes.
16. Have you observed any facial hair growth during your menstrual cycle? ☐No. ☐Yes.
17. Have you observed any hair loss or hair thinning? ☐No. ☐Yes.
18. Do you get pain in your pelvis before the period starts? ☐Never. ☐Occasionally. ☐Sometimes. ☐Very often.
19. Do you experience bleeding with bowel movements? ☐Never. ☐Occasionally. ☐Sometimes. ☐Very often.
20. Is sexual intercourse painful? ☐Never. ☐Occasionally. ☐Sometimes. ☐Very often.
21. Is urination painful? ☐Never. ☐Occasionally. ☐Sometimes. ☐Very often.
22. Are you experiencing burning and/or pain around your external genitalia? ☐No. ☐Yes.
23. Have you noticed a bright red rash around your genitalia? ☐No. ☐Yes.
24. Do you experience vaginal discharge? ☐No. ☐Yes. If yes, how often?_____.
25. If yes to #24 does it appear white and curd like? ☐No. ☐Yes.
26. Do you have itching combined with soreness or burning around your genitalia? ☐No. ☐Yes.
27. Have you taken any antibiotics within the past year? ☐No. ☐Yes.
28. Are you currently menopausal or have undergone menopause? ☐No. ☐Yes.
29. If yes to #28, how many years since your menopause began? ☐No. ☐Yes.
30. Do you have spotting during your menses? ☐No. ☐Yes.
31. Do you get hot flashes? ☐No. ☐Yes. If yes, how often?_____.
32. Have you been experiencing mental fogginess? ☐No. ☐Yes.
33. Have you noticed a disinterest in sex? ☐No. ☐Yes.
34. Are you experiencing any type of mood swings? ☐No. ☐Yes.
35. Do you feel sad or depressed lately? ☐No. ☐Yes.
36. Is sexual intercourse painful or difficult for you? ☐No. ☐Yes.
37. Have you noticed the size of your breasts getting smaller? ☐No. ☐Yes.
38. Are you experiencing acne or pimples? ☐No. ☐Yes.
39. Are you experiencing decreased vaginal lubrication or vaginal dryness? ☐No. ☐Yes.
40. Are you experiencing vaginal itching? ☐No. ☐Yes.

Doctor's Notes:_____

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