

# Female Health History Form I

Patient's name \_\_\_\_\_ Age \_\_\_\_\_ Date \_\_\_\_\_

## MENSTRUAL HISTORY:

Age when started menstruating: \_\_\_\_\_  
Length of cycle in days \_\_\_\_\_  
Length of period in days \_\_\_\_\_  
Last Menstrual Period \_\_\_\_\_  
Quality of Flow (dark red, bright red, clots)  
Describe: \_\_\_\_\_  
Quantity of Flow: (light, moderate, heavy)  
Quantify (how many pads/tampons): \_\_\_\_\_  
Are cycles regular? Yes No  
Endometriosis Yes No Present  
Uterine Fibroids Yes No Present  
Ovarian Cysts Yes No Present

## SEXUAL HISTORY:

Sexually Active? Currently Past Never  
Partners? Male Female Both  
Satisfied with sexual life? Yes No  
Any Concerns?  
History of STD:(circle all that apply)  
Herpes Simplex Virus II (HSVII)  
Human Papilloma Virus (HPV)  
Gonorrhea  
Chlamydia  
Syphilis  
Hepatitis  
HIV  
History of Vaginitis: (circle)  
Trich  
Vaginal Candidiasis  
Bacterial Vaginosis

## OBSTETRICAL HISTORY:

Number of children \_\_\_\_\_  
Number of Pregnancies \_\_\_\_\_  
Voluntary abortions \_\_\_\_\_  
Miscarriages/involuntary abortions \_\_\_\_\_  
Difficulty with:  
Conceiving \_\_\_\_\_  
Pregnancy \_\_\_\_\_

Labor/Delivery \_\_\_\_\_

History of breastfeeding:  
Future OB plans: \_\_\_\_\_  
\_\_\_\_\_

## CONTRACEPTIVE HISTORY:

Current method: \_\_\_\_\_  
Satisfied? Yes No  
Past Methods: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## RISK ASSESSMENT:

Knowledge of safer sex methods: Yes No  
Use of safer sex methods? Yes No  
IV Drug Use: Yes No When \_\_\_\_\_  
Blood transfusions/blood products: Yes No  
When \_\_\_\_\_  
Sexual activity with:  
IV drug user: Yes No When \_\_\_\_\_  
Bisexual Male • Bisexual Female • Prostitute?  
Yes No  
Abnormal Pap Yes No When \_\_\_\_\_

## NOTES:

## Female Health History Form II

CIRCLE IF YOU EXPERIENCE ANY OF THESE SYMPTOMS WITHIN 3 DAYS TO TWO WEEKS PRIOR TO MENSTRUATION.

Symptom	Mild	Mod	Severe
Insomnia	1	2	3
Abdominal Bloating	1	2	3
Breast tenderness or Swelling	1	2	3
Depression	1	2	3
Irritability	1	2	3
Nausea	1	2	3
Anger	1	2	3
Irritability	1	2	3
Diarrhea or constipation	1	2	3
Headache	1	2	3
Food cravings	1	2	3
Back pain	1	2	3
Sad, easy to cry	1	2	3
Weight gain - water	1	2	3
Breast lumps appear	1	2	3
Acne	1	2	3

CIRCLE, IF YOU EXPERIENCE ANY OF THESE SYMPTOMS DURING YOUR PERIOD.

Pain, Cramps	1	2	3
Irritable & depressed	1	2	3
Constipation or diarrhea	1	2	3
Low back pain	1	2	3
Nausea or vomiting	1	2	3
Unusual fatigue	1	2	3
Vaginal Herpes	1	2	3
Headache	1	2	3

CIRCLE, IF YOU EXPERIENCE THESE SYMPTOMS AT ANY TIME.

Vaginal dryness, pain	Y	N
Painful intercourse	Y	N
Disinterest in sex	Y	N
High sex drive	Y	N
Absence of menstrual flow for 6 or more months	Y	N
Occasionally skip periods	Y	N
Menses began after age 16	Y	N
Breasts shrinking	Y	N
Inability to get pregnant	Y	N
Miscarriage	Y	N
Excess Facial hair	Y	N
Milk production	Y	N
Menstrual type pain between menses	Y	N
Extended menses (greater than every 32 days)	Y	N
Shortened menses (less than every 24 days)	Y	N
Irregular menstrual cycle	Y	N
Vaginal bleeding between periods	Y	N
Abnormal vaginal discharge	Y	N
Pain during periods is getting progressively worse	Y	N
Vaginal itching or pain	Y	N
Easy bruising	Y	N
Hot flashes	Y	N
Cravings for sweets	Y	N