Women's Reproductive Health Intake

At what age did your first menstrual period start? _____

Date of Last Menstrual Period? ___/___/___ What is the length of menses itself? _____ Days

What is the length of menstrual cycle? _____ Days

Do you ever experience PMS? YES/NO Cramping? YES/NO If so when? _____

Clotting? YES/NO Light flow? YES/NO Excessive flow? YES/NO Other: _____

Have you experienced any of the following, past or present? PLEASE CIRCLE

Breast pain	Irregular PAP	Difficulty getting pregnant	Fibroids
Endometriosis	Ovarian cysts	STD's including HPV	Vaginal dryness
Vaginal infection	Hot flashes	Irregular menstrual cycles	Pelvic pain
Difficult menopause	Currently pregnant	Caesarian section	VBAC
Migraines	Acne	Urinary tract infection	Candida

Cancer: If yes, what type and treatment: _____

Date of last pelvic exam? ____/____/____

Have you ever been told you have a tipped or tilted uterus? YES/NO

List the dates and years of any children you have birthed and type of delivery
(V = Vaginal, C = Caesarian, VB = Vaginal following Caesarian):

_____

_____

_____

_____

Location of birth (hospital, birthing center, home):

_____

Practitioner(s) in attendance (doctor, nurse midwife, lay midwife, unattended):

_____

Any problems post-partum_____

Did you breastfeed your child(ren): YES/NO If yes, how long? _____

Have you had any miscarriages? ___ If so, when? _____

Women's Reproductive Health Intake

Have you had any abortions? ___ If so, when? _____

Method(s) of contraception taken past and present:

_____

At what age did you start using contraception and which type? _____

Have you had an IUD ? YES/NO If yes, which one(s) and date(s) of insertion and removal:

_____

Do you have any pain with intercourse? YES/NO Do you have difficulty achieving orgasm? Y/NO

Do you have any problems with incontinence (difficulty holding your urine)? YES/NO

MENOPAUSE:

Have you entered Menopause yet? YES/NO If so, at what age? _____

Have you experienced any of the following, past or present? PLEASE CIRCLE

Hot flashes	Memory loss	Depression	Insomnia
Mood swings	Fatigue	Vaginal dryness	Night sweats
Osteoporosis	Irregular cycles	Waking early	Anxiety
Dry skin	Dry scalp	Hair loss	Irritability
Reduced libido	Painful intercourse	Acne	Other: _____

Do any of the women on your mother's side of the family suffer from any of the following:
Infertility ___ Menstrual Problems ___ Difficult Menopause ___

Are you now, or have you ever taken: Hormone Replacement Therapy? YES/NO

If yes, when did you start taking it and for how long? _____