GYNECOLOGY INFORMATION

Name_____ Date_____

Age menses began_____ Date last period began_____

Length of cycle_____days Length of menses_____days

Days of heavy menstrual flow_____ Days of light menstrual flow_____

Blood color □pink □red □dark red □purple Blood clotting □yes □no

Cramping or painful periods □yes □no Location_____

PMS □yes □no If yes, please describe_____

Cramping or bleeding between periods □yes □no

Irregular menstrual cycle □yes □no

Vaginal discharge: color_____ quantity_____ odor_____

Vaginal sores □yes □no Breast lumps □yes □no

Number of pregnancies_____ Number of live births_____

Number of miscarriages/abortions_____ Date of last gynecological exam_____

History of:
- oral contraceptives □yes □no
- sexually transmitted diseases □yes □no
- endometriosis □yes □no
- ovarian cysts □yes □no
- fibroids □yes □no
- uterine polyps □yes □no
- abnormal pap smear □yes □no
- operations □yes □no
- urinary tract infections □yes □no
- vaginal infections □yes □no
- yeast infections □yes □ no
- other □yes □no