

**AS OF NOW DO YOU HAVE ANY OF THE FOLLOWING SYMPTOMS?**

Please circle YES or NO answers

<b>Lymphatics</b>			<b>Pulmonary</b>			<b>Musculoskeletal</b>		
adenopathy - enlarged glands	Yes	No	productive cough	Yes	No	varicose veins	Yes	No
diseases of the lymphatics	Yes	No	asthma	Yes	No	joint, back or neck pain	Yes	No
<b>Skin System</b>			sleep apnea	Yes	No	muscle pain or cramping	Yes	No
skin rash	Yes	No	<b>Gastrointestinal</b>			sciatic nerve pain	Yes	No
disease of the skin	Yes	No	abdominal pain	Yes	No	<b>Endocrine</b>		
<b>Heart System</b>			constipation	Yes	No	intolerance of heat or cold	Yes	No
eyes-visual changes	Yes	No	jaundice	Yes	No	unusual growth of hair	Yes	No
ears-ear infections	Yes	No	nausea/vomiting	Yes	No	<b>Central Nervous System</b>		
nose-sinus problems	Yes	No	weight gain or loss	Yes	No	loss of memory	Yes	No
<b>Cardiovascular</b>			rectal bleeding	Yes	No	sleep disturbance	Yes	No
heart problems	Yes	No	<b>Genitourinary</b>			mood swings	Yes	No
chest pain	Yes	No	kidney stones	Yes	No	loss of coordination	Yes	No
tachycardia	Yes	No	blood with voiding	Yes	No	tingling of extremities	Yes	No
rheumatic fever	Yes	No	nocturia (get up at night to urinate)	Yes	No	fatigue	Yes	No
excessive bleeding from cuts	Yes	No	breast lump or discharge	Yes	No	headaches	Yes	No
bruise easily	Yes	No	urinary frequency	Yes	No			
			frequent urinary tract infections	Yes	No			
			urgency to urinate	Yes	No			
			stress incontinence-(leak urine when cough or laugh)	Yes	No			
			sexually transmitted disease	Yes	No			
			night sweats	Yes	No			
			breast pain, lump or discharge	Yes	No			

**MENSTRUAL HISTORY**

Started age \_\_\_\_\_ regular \_\_\_\_\_ irregular \_\_\_\_\_  
 Average number of days from start of next period \_\_\_\_\_  
 Number of days bleeding lasts \_\_\_\_\_ Date of last normal period (1st day) \_\_\_\_\_  
 Menstrual flow is usually: scant \_\_\_\_\_ moderate \_\_\_\_\_ heavy \_\_\_\_\_; Clots Yes No  
 Are your periods painful? Yes No If yes, describe \_\_\_\_\_  
 Do you ever bleed between periods?  
 Do you bleed after intercourse or douching?  
 Is intercourse satisfactory? Yes No Painful? Yes No  
 Time with present partner \_\_\_\_\_  
 Do you get tense before your period?  
 Have you ever been treated for pelvic infection before? Yes No  
 Do you have a discharge? Yes No Color \_\_\_\_\_ Odor? Yes No  
 Itch? Yes No

Have you been treated for vaginal infection before?  
 Yes No Fungus-Yeast  
 Yes No Trichomonas  
 Yes No Gonorrhoea  
 Yes No Syphilis  
 Yes No Herpes  
 Yes No Venereal warts (HPV)  
 Yes No Chlamydia  
 Yes No Gardnerella  
 Yes No Other

Do you Douche? Yes No How often? \_\_\_\_\_  
 Date of last PAP SMEAR \_\_\_\_\_ If yes, what treatment was used?  
 Do you have a history of abnormal PAP SMEARS? Yes No Cryosurgery \_\_\_\_\_  
 Laser surgery \_\_\_\_\_  
 Cone biopsy \_\_\_\_\_  
 Electrocautery \_\_\_\_\_

**OBSTETRICAL HISTORY**

How many pregnancies have you had? \_\_\_\_\_  
 How many sets of twins do you have? \_\_\_\_\_  
 How many children born alive? \_\_\_\_\_  
 How many cesarean births? \_\_\_\_\_  
 How many premature births? \_\_\_\_\_  
 How many miscarriages? \_\_\_\_\_  
 How many abortions? \_\_\_\_\_  
 How many tubal/ectopic pregnancies? \_\_\_\_\_  
 How many stillbirths? \_\_\_\_\_

**CONTRACEPTIVE HISTORY**

Are you trying to get pregnant? Yes No  
 Do you have trouble getting pregnant? Yes No  
 Do you or your partner use a birth control method? Yes No

Check method:  
 \_\_\_\_\_ Natural/Rhythm \_\_\_\_\_ Cervical cap  
 \_\_\_\_\_ Withdrawal \_\_\_\_\_ IUD  
 \_\_\_\_\_ Abstinence \_\_\_\_\_ Pill  
 \_\_\_\_\_ Rubber Condom \_\_\_\_\_ Norplant  
 \_\_\_\_\_ Foam \_\_\_\_\_ Tubal ligation  
 \_\_\_\_\_ Vaginal suppository \_\_\_\_\_ Vasectomy  
 \_\_\_\_\_ Sponge \_\_\_\_\_ Other  
 \_\_\_\_\_ Diaphragm

Comments or problem with method: \_\_\_\_\_

**CHILDREN**

	Sex	Yr. Born	Mos. of Preg.	Length of Labor	Birth Wt.	Complications
1.						
2.						
3.						
4.						
5.						