

Name: _____

Date: _____

WOMEN'S HEALTH FORM

How old were you when you had your first menstruation? _____ yrs. old

Date of last menstruation? _____ Is your cycle: Regular Irregular
 Often Early Often Late

Cycle length (i.e. 28 days)? _____ How many days do you bleed? _____

Number of pregnancies _____ Number of live births _____ Ages of children _____

Were there any problems during or after any of these pregnancies? Yes No

Please specify: _____

Any abortions? Yes No

Are you pregnant or breastfeeding? _____

Do you spot or bleed outside your normal flow? Yes No

If yes, when? Mid-cycle Before start of period End of period

Describe your flow. Heavy Light Average

What color is the blood? Pink Bright Red Dark Red Purple Brown Black

Consistency of blood? Watery/thin Average Thick

Does your menstruation contain clots? Yes No

At what point during the cycle? Start Middle End

What size are the clots? Large Small

Do you experience menstrual pain? Yes No

If yes, at what point of the cycle? Before During* After

*If during, what days? (i.e. days 2&3) _____

What type of pain is it? Stabbing Dull On & Off Cramping Heavy

What relieves the pain? (i.e. pressure, cold, heat) _____

Do you experience nipple sensitivity or discharge? Yes No

Do you experience Pre-menstrual Symptoms (PMS)? (*Check all that apply*)

Breast tenderness Cramps Acne Change in bowel movements Bloating

Headaches Nausea Moodiness Fatigue Disturbed Sleep

Other _____

Do you notice a difference in energy or fatigue around your period? (More energy / fatigue)
 Before During After N/A

Do you experience pain around ovulation? Yes No

Do you notice cervical mucous around time of ovulation? Yes No
 Quality: Stretchy & Clear White Dry

Do you ovulate on your own? Yes No

Comments regarding ovulation/menstruation:

Have you taken oral contraceptives? Yes No
 How long? _____ When did you stop? _____

Have you ever had an IUD? Yes No
 How long? _____

Have you ever taken Depo-Provera? Yes No

Do you experience excess vaginal secretions (discharge)? Yes No
 Colour: White Yellow Greenish Pinkish Red
 Consistency: Water Thick Sticky
 Odour: Normal Unpleasant Foul

Date of last Pap smear (mm/dd/yy) _____

Have you ever had an abnormal pap smear? Yes No

Have you ever had a cervical biopsy, operation, and/or cauterization? Yes No

Do you get yeast infections regularly? Yes No

Do you get bladder infections regularly? Yes No

Have you ever been diagnosed with Chlamydia infection? Yes No

Have you ever had pelvic inflammatory disease? Yes No
 If yes, were you treated for it? How? _____

Have you ever been diagnosed with:

Uterine fibroids?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Polyps?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Pelvic adhesions?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Prolapsed uterus?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Pelvic abnormalities?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Endometriosis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
PCOS (Polycystic Ovarian Syndrome)	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Additional comments or questions:

How long have you been trying to conceive? _____

Have either you or your partner had a diagnosis relating to infertility? Yes No

Have you taken medication to help you ovulate? Yes No
 If yes, what kind? _____ For how many cycles? _____

Have your fallopian tubes been evaluated medically? Yes No
 What were the results? _____

Have you had any tubal operations? Yes No

Have you had any hormone laboratory tests performed?

FSH	<input type="checkbox"/> Normal	<input type="checkbox"/> High	
Prolactin	<input type="checkbox"/> Normal	<input type="checkbox"/> High	
Thyroid	<input type="checkbox"/> Normal	<input type="checkbox"/> High	<input type="checkbox"/> Low
Progesterone	<input type="checkbox"/> Normal	<input type="checkbox"/> High	<input type="checkbox"/> Low
Testosterone	<input type="checkbox"/> Normal	<input type="checkbox"/> High	<input type="checkbox"/> Low
Other _____	<input type="checkbox"/> Normal	<input type="checkbox"/> High	<input type="checkbox"/> Low

Have you ever had fertility treatments? (IVF, IUI, etc.) Yes No

Month/Year	Type of Treatment	Clinic
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

How did you respond to the fertility treatments? Poor Response Average/Good Response

Comments:

Do you use basal body temperature charts, ovulation sticks or saliva ferning to check your ovulation cycle? Yes No

Have you been exposed or received chemotherapy or radiation? Yes No

How is your sexual desire (mental interest)? Low Normal High

How is your sexual arousal (physically aroused/orgasm)? Low Normal High

Do you use vaginal lubricants? Yes No

Are you more than 20% over your ideal body weight? Yes No

Are you more than 20% below your ideal body weight? Yes No

Do you have excessive facial/body hair? Yes No

Do you have excessive oily skin? Yes No

Have you experienced excessive loss of head hair? Yes No

*Please ensure that you complete the **Health History Questionnaire** and **Patient Information & Consent Form**