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Gynecology Questionnaire

Age of first menses?: _____ Date of last menstrual period?: _____

Duration of flow?: _____ Length of cycle: _____ Blood clots?: yes no

Color of menstrual blood?: pale bright red dark red brown

Other?:

_____

_____

Texture of menstrual blood?: thick thin watery regular to you

Pain?: yes no When: Before During After Mild Strong or Severe? Describe:

_____

Irregular periods (describe)?:

_____

_____

PMS (describe)?:

_____

_____

Current method of contraception?: _____

Past method of contraception?: _____

Are you currently pregnant? yes no

Number of pregnancies?: _____ Number of live births?: _____

Number of miscarriages?: _____ Number of abortions?: _____ Number of premature births?: _____

Breasts (lumps, cysts, tenderness, discharge, etc.)?:

_____

Do you complete Self breast exam monthly? Yes no

When was your last clinical breast exam from your primary health care provider?

_____Findings? _____

Last mammogram? _____ Last sonogram?_____

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Urinary tract infections?: yes no

How frequent?: _____

_____

Vaginal infections/discharge?: yes no

How frequent?:_____

_____

Describe color/consistency/odor: _____

_____

Pain/itching of genitalia?: yes no Describe: _____

_____

Date of last Pap smear?: _____ normal abnormal

Findings?:

_____

Uterine fibroids?: yes no Endometriosis?: yes no Other?

_____

Abnormal bleeding? _____

Menopause (date of onset)?: _____

Symptoms?: _____

_____

_____

_____

_____

Any bleeding since?: yes no When?:

_____

Are you currently on Hormone Replacement Therapy (HRT)? yes no Dose?:

_____

How long have you been on HRT?: _____ Any side effects?:

_____

_____

Other gynecological information of note?: _____


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