Dr. Anne Marie Palzer

WOMEN'S HEALTH HISTORY

Patient Name _____ DOB/Age_____

What was your age at your first menstruation?_____.

What was the first day of your last menstrual period?_____. How long did it last?_____. How many days on average between periods?_____. Is your cycle regular? ___Yes ___No.

Do you use tampons or pads or both?_____ . How many of each on your heaviest day?_____.

Do you experience menstrual cramps? ___Yes ___ No

Other problems *during* menstruation?_____.

Premenstrual Warning Symptoms (*Before your period*) Please check all that apply.
__Breast tenderness
__Headache
__Low back pain
__Bloating
__Cramping
__Constipation
__Diarrhea
__Skin problems
__Mood changes
__Appetite changes/cravings
__Other (*please explain*)_____
_.

Do the above symptoms get better when your period starts? __Yes __No.

Do you have any vaginal discharge or irritation currently? ___Yes ___No.

Do you have any recurring vaginal or bladder infections? ___Yes ___No.

Have you ever had any type of gynecological or breast surgeries/biopsies? ___Yes ___No.

Do you have a past or current history of: herpes, venereal warts, or STD's? ___Yes ___No.

When was your last pap?_____. Was it normal? ___Yes ___No.

Do you have hot flashes? ___Yes ___No. Vaginal dryness ___Yes ___No.

Breast problems: None__ Discharge__ Tenderness__ Swelling__

Did you breastfeed your babies?_____. For how long?_____.

Current Method of Birth Control: __Non-applicable __No method
__Diaphragm __Pill, name_____ for how long_____
__IUD ___Depo-provera injection ___Hysterectomy __Condoms
__Foam __Tubal ligation __Partner has vasectomy/is sterile __Other

Name all previous methods of birth control_____.

Any problems or questions regarding sex? __yes __no.

Any pain or discomfort during sexual intercourse? __yes __no.

Number of times pregnant____ Number of children living____ Miscarriages_____

Abortions____ Premature births____

Pregnancy information:

Born Mo/Yr & sex	Birth weight	Length of Pregnancy	Delivery type	Complications