

Gynecology Intake Forms

Date last menses began/ _____ Is your menstrual cycle: Regular _____ Irregular _____

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

How many days do you bleed in total? _____ Menstrual Cycle length (i.e. 26-30 days) _____

Describe your flow: Heavy _____ Light _____ Average _____

Consistency of blood: Watery _____ Thick _____ Average _____

Does your blood contain clots? Yes _____ No _____

...and ... At which point during the cycle? Start _____ Mid _____ End _____

Describe the Colour of your blood: (dark red, brown, purple, brownish red, bright red, pink etc.)

Do you experience menstrual pain? Yes _____ No _____ Before menses _____ During _____ (Please specify which days) After _____ What relieves the pain? _____

_____ -What relieves the pain? _____ -

Stabbing _____ Cramping _____ Dull _____ Heavy _____ On/Off _____

Do you experience Pre-menstrual Symptoms (PMS)? Please Check All that Apply

Breast Tenderness _____ Cramps _____ Acne _____ Change in Bowel _____ Bloating _____ Headaches _____
Nausea _____ Moodiness _____ Fatigue _____ Night Sweats _____ Sleep Disturbances _____

Please List any other symptoms:

Do you ovulate on your own? Yes ___ No___ What Day?___

Do you chart your cycle? (Circle) BBT / Ovulation Sticks / Saliva

Do you experience pain around ovulation? Yes___ No ___

Do your breasts get tender around ovulation? Yes___ No___

Do you notice stretchy clear egg white slippery cervical mucous around ovulation? Yes___
No___

How many times have you been pregnant?___How many times have you given birth?_____

Ages of children _____Sex of Children_____ -

Given Names_____--have you had any miscarriages? Yes No

If yes, how many, at how many weeks pregnant and in what years?

How many times have you had a D & C performed?

How many abortions have you had? In what year(s)?

Were there any problems that occurred during these pregnancies?

Have you ever been diagnosed with:

STD

Pelvic Inflammatory Disease

Uterine Fibroids

Polyps

Pelvic Adhesions

Prolapsed uterus

Unique shape of uterus

Endometriosis

PCOS (Polycystic Ovarian Syndrome)

Date of last pap smear ____/____/____ (dd/mm/yy)

Have you ever had an abnormal pap smear? Yes ____ No ____

Have you ever had a cervical biopsy or operation? Yes ____ No ____

Do you get yeast infections regularly? Yes ____ No ____

Do you get bladder infections regularly? Yes ____ No ____

If answered yes, list STD's:

Do you experience vaginal discharge? Yes ____ No ____

If yes, what color?

White ____ Yellow ____ Green ____ Pinkish ____ Red ____ Clear ____

If yes, what consistency?

Watery/Thin ____ Thick ____ Sticky ____

If yes, does it have a foul odour? Yes ____ No ____

Have you taken oral contraceptives? Yes ____ No ____

If yes, for how long?

When did you stop?

Have you ever had an IUD? Yes ____ No ____

Have you ever taken Depo-Provera? Yes ____ No ____