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## FEMALE HISTORY

**NAME:** \_\_\_\_\_

**AGE:** \_\_\_\_\_

**BIRTHDATE:** \_\_\_\_\_

**FAMILY HISTORY:** Any history of the following in your immediate family (Mother, Father, Siblings):

Alcoholism \_\_\_\_\_

Birth Defects \_\_\_\_\_

Breast Disease \_\_\_\_\_

Cancer \_\_\_\_\_

Diabetes (on insulin) \_\_\_\_\_

Heart Disease \_\_\_\_\_

High Blood Pressure \_\_\_\_\_

Infertility/Miscarriage \_\_\_\_\_

**GENERAL HEALTH HISTORY:** Please indicate if you have ever experienced any of the following:

Headaches     Asthma     Drug Abuse     High Blood Pressure     Thyroid Disease  
 Migraines     Diabetes     Heart Murmur     Pain with intercourse     Breast Discharge  
 Cancer     Anxiety     Heart Disease     Mammogram (date \_\_\_\_\_)     Breast pain/lumps  
 Depression     Back Pain     Kidney Disease     Abnormal Hair Growth     Liver Problems  
 Other \_\_\_\_\_

**Any known drug allergies:** \_\_\_\_\_

Current medications that you are taking: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Has your weight changed more than 10 lbs In the past year?     NO     YES

Have you ever had a blood transfusion?     NO     YES    If so, when? \_\_\_\_\_

**SURGICAL HISTORY:** Please list all surgical procedures that you have had:

DATE	TYPE OF SURGERY	PHYSICIAN	FINDINGS (IF ANY)

**MENSTRUAL HISTORY:**

How old were you when your period began? \_\_\_\_\_ Are they regular?     NO     YES

What is the usual interval between the start of one period and the start of the next? \_\_\_\_\_

How many days does your period last? \_\_\_\_\_ Is the flow heavy, moderate or light? \_\_\_\_\_

Do you have bleeding between your periods?     NO     YES

Do you have cramps?     NO     YES    If yes, every cycle     NO     YES

Do you take any medications for pain relief?     NO     YES    If yes, list \_\_\_\_\_

Do you get moody, depressed or bloated?     NO     YES

**When was the first day of your last period?** \_\_\_\_\_

