MARIA MITCHELL LAC, MTCM
WOMENS HEALTH HISTORY

This is a confidential questionnaire to help determine the best treatment option for you. Please fill out completely and accurately as possible even if you do not feel certain questions pertain to your present condition. Thank you.

Age of first menses: ____
Are you, or might you be pregnant? Y / N
Number of days of flow: __
Date of last Pap smear: _____

Date of last menses: _____
Number of days between periods (your cycle): _
Is your cycle regularly the same length? Y / N

Color of Flow	**Amount of Flow**	**Number of Pads/Tampons Used per Day**	**Pain & Cramping**
__ Red	__ Spotting	1st Day __	__ No
__ Bright Red	__ Light	2nd Day __	__ Yes
__ Dark Red	__Even Throughout	3rd Day __	__ Before Flow __Mild
__ Dark Red/ Brown	__ Heavy	4th Day __	__ During Flow__Mod
__ Clots		+ Days __	__ After Flow __ Sev
__ Powdery/ Dry			

What else do you experience premenstrual, during, after, and around ovulation?

_____

_____

_____

Of Pregnancies ___ Births __ Abortions __ Miscarriages __
Have you ever had an abnormal pap smear? Y/N
Have you ever had a cervical biopsy, operation, cauterization Y/N?
Do you get yeast infections regularly? Y / N Urinary tract infections? Y / N
Have you ever been diagnosed with or treated for?

☐ Chlamydia infection	☐ Pelvic inflammatory disease	☐ Endometriosis
☐ Polycystic ovaries	☐ Ovarian Cysts	☐ Pelvic adhesions
☐ Pelvic abnormalities	☐ Uterine fibroids	☐ Uterine polyps
☐ Other _____		

Do you use birth control, and if so, what method? _____
Have you ever taken birth control pills, and if so, for how long? _____
How regularly do you have breast exams? What kind? _____
Are you having any symptoms related to menopause? _____
Do you have any libido concerns? _____
Family History of Ovarian, Uterine, Cervical, Breast or Prostate Cancer? _____
Gynecologist/Nurse Practitioner _____