Name: ____________________

# Women's Health Center, PC

## Personal Gynecological History

Date of your last period? __________ How often? (first day to first day) __________ How long is your flow? __________

Pain/Cramping? ❑ YES ❑ NO    Nausea/Vomiting? ❑ YES ❑ NO
Clotting? ❑ YES ❑ NO    Diarrhea? ❑ YES ❑ NO

Your age at first period? __________

Date of last pap smear? __________ ❑ Normal ❑ Abnormal If abnormal, results: __________

Have you ever had an abnormal pap smear? ❑ YES ❑ NO If yes, when? __________ Results? __________

Date of last mammogram? __________ Where? __________ Results? __________

What do you use for birth control?

| | | | |
|---|---|---|---|
| ❑ Nothing | ❑ Birth control pills | ❑ Condoms | ❑ Diaphragm |
| ❑ Spermicides | ❑ IUD | ❑ Abstinence | ❑ Withdrawal |
| ❑ Implants | ❑ Female sterilization (tubal) | ❑ Male sterilization (vasectomy) | ❑ Other __________ |
| ❑ Depo Provera injections | ❑ Gay/Lesbian | ❑ Rhythm | |