NURTURING HEALTH
Naturopathic Clinic

GYNECOLOGIC HISTORY FORM

Name: _____ DOB (dd/mm/yy): ___ / ___ /___ Date: ___/ ___/ ___

General Gynecologic History

Date of last gynecologic exam and PAP test: (dd/mm/yy) ___ / ___ / ___
Any history of abnormal PAP tests? If so, what grade and how was it treated?

_____
_____
_____

What is your experience with gynecologic exams (describe any difficulties, issues)?

_____
_____
_____

First day of last menstrual period: (dd/mm/yy) ___/___/___
Age of first menstrual cycle: _____
Do you have regular cycles? _____
Cycle length (number of days from first day of a period until first day of the next)? _____
Duration (number of days of bleeding) _____
Characteristics of menstrual flow & PMS (PMS, clots, cramping, excessive bleeding):

_____
_____

Amenorrhea (3+ consecutive months without a period)? □ Current □ Past
Date of onset: (mm/yy) _____/ _____ Duration of amenorrhea: _____ months (total)

Any surgery on ovaries, or uterus? □ Yes □ No If yes, please list procedure & date:

_____

Please check the appropriate boxes:

Ovarian cysts	□ Current □ Past
Ovarian tumors	□ Current □ Past
Fibroids	□ Current □ Past
Endometriosis	□ Current □ Past
Candida/yeast infections	□ Current □ Past

Total number of infections per year & treatment: _____

NURTURING HEALTH
Naturopathic Clinic

Other (HPV, genital warts) _____ □ Current □ Past

Are you sexually active? □ Yes □ No How many partners? _____
What method of birth control (if any) are you currently using? _____

Any abnormal vaginal discharge? □ Yes □ No
If yes, describe the vaginal discharge below:

_____

_____

Color: _____
Odor: _____
Consistency: _____
Frequency of discharge: _____

Any history of STDs? □ Yes □ No
Please check below:

Chlamydia	□ Current	□ Past	date of onset: ___ / ___ (mm/yy)
PID	□ Current	□ Past	date of onset: ___ / ___ (mm/yy)
Gonorrhea	□ Current	□ Past	date of onset: ___ / ___ (mm/yy)
Syphilis	□ Current	□ Past	date of onset: ___ / ___ (mm/yy)
Herpes	□ Current	□ Past	date of onset: ___ / ___ (mm/yy)
Trichomonas	□ Current	□ Past	date of onset: ___ / ___ (mm/yy)

Medication and Birth Control History

Please outline your history of birth control use below (OCP, IUD, DEPO, etc.), including duration of use:

_____

_____

_____

_____

Do you smoke? □ Current □ Past Total number of years: _____

Pregnancy History

Number of pregnancies? _____ Number of births? ____ Number of miscarriages? _____
Number of abortions? _____ History of tubal or ectopic pregnancies? □ Yes □ No
Difficulty conceiving? □ Current □ Past ____ months (or) years trying to conceive
Fertility treatment? □ Yes □ No If yes: □ Current □ Past ____ months (or) years
Please describe type of fertility treatment:

_____