



San Francisco Integrative Medicine
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Women's Health History

CONFIDENTIAL

Please provide the following information:

1. Age at which menses began _____
 2. Date of the first day of your last period _____
 3. Number days bleeding lasts _____
 4. Number of days in your cycle _____
 5. Have your cycles changed since they first began? Yes No
How? _____
 7. Are you currently pregnant? Yes No
 8. Menstrual Flow:
 Heavy Moderate Light None
 9. Color of Menstrual Flow:
 Light Red Red/Purple Dark Red Brown
 10. Cramping:
 Severe Moderate Mild None
 Before period During After period
 11. Clotting:
 Large Medium Small None
 Bright in color Dark in color
 12. Birth Control:
 None IUD
 Barriers Spermicides
 Rhythm method Condoms
 Birth control pills
 13. How many pregnancies have you had? Number _____ Year _____
 14. How many children do you have?
 15. How many abortions have you had?
 16. How many miscarriages have you had?
 17. Have you ever had an abnormal pap smear? Yes No Date _____
 18. Have you ever had a cervical biopsy, operation, cauterization, or conization? Yes No Date _____
 19. Have you ever been diagnosed with Chlamydia? Yes No
 20. Do you have chronic vaginal discharge? Yes No If yes, what color? _____
 21. Have you gone, or are you currently going through menopause? Yes No Age of menopause _____
If yes, are you currently taking any medications or hormone replacement therapy? Yes No Type _____
- Please check any of the premenstrual syndrome symptoms that apply:
- | | | | |
|---|---------------------------------------|--|--------------------------------------|
| <input type="checkbox"/> Fluid retention/Bloating | <input type="checkbox"/> Cravings | <input type="checkbox"/> Acne/Break outs | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Mood swings | <input type="checkbox"/> Irritability | <input type="checkbox"/> Back pain | |
| <input type="checkbox"/> Breast tenderness | <input type="checkbox"/> Depression | <input type="checkbox"/> Fatigue | |
- Please check any that apply:
- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Infertility | <input type="checkbox"/> Ovaries removed | <input type="checkbox"/> Mastitis |
| <input type="checkbox"/> Breast cysts | <input type="checkbox"/> Brain fog | <input type="checkbox"/> Pelvic inflam. disease | <input type="checkbox"/> Frequent UTI |
| <input type="checkbox"/> Vaginal discharge | <input type="checkbox"/> PCOS | <input type="checkbox"/> Fibroids/cysts | <input type="checkbox"/> Irregular periods |
| <input type="checkbox"/> Abnormal pap smear | <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Post-menopausal bleeding | <input type="checkbox"/> Abnormal mammogram |
| <input type="checkbox"/> Pain/itching of the genitalia | <input type="checkbox"/> Bleeding between periods | <input type="checkbox"/> Recurrent yeast infection | <input type="checkbox"/> Nipple discharge |
| <input type="checkbox"/> Hot flashes | <input type="checkbox"/> Vaginal dryness | <input type="checkbox"/> Moodiness | <input type="checkbox"/> Other _____ |