

Female Patient Questionnaire

Name: _____ **Date:** _____

Date of Birth: _____ **Referred By:** _____

Date Of Your First Menstruation. _____

Are You Now, Or Have You Ever Uses Birth Control Pills? ☐ Yes ☐ No

Do You Have PMS? ☐ Yes ☐ No

Do You Have Difficult Periods? ☐ Yes ☐ No

Do You Have Clots? ☐ Yes ☐ No

Any Vaginal Discharges Now, Or In The Past? ☐ Yes ☐ No

Do You Have, Or Have You Had Lumps In The Breasts? ☐ Yes ☐ No

How Many Pregnancies? _____

How Many Live Births? _____

How Many Cesarian Section (C-Section) Births? _____

Have You Had Any Miscarriages? _____

Have You Had Any Abortions? _____

Are You In Menopause? ☐ Yes ☐ No

If Yes, When Did It Start? _____

Do You Have Any Hot Flashes? ☐ Yes ☐ No

Have You Ever Had Any Cysts On The Ovaries? ☐ Yes ☐ No

Any History Of Fibroids On The Uterus? ☐ Yes ☐ No

Have You Had A Hysterectomy? ☐ Yes ☐ No

Any History Of Endometriosis? ☐ Yes ☐ No

Any History Of Rape? ☐ Yes ☐ No