

Gynecological Intake Form

Name: _____

Date: _____

(please circle all that apply)

- Age of first period: _____
- Date of last period: _____
- # days between periods: _____
- # days bleeding total: _____
- # days spotting: Before: _____ After: _____
- Irregular bleeding (please describe, e.g starts and stops)

Previous Medical Diagnoses: _____

OB-GYN Surgeries: _____

Medications (amount) used for GYN issues: _____

Period:

- **Flow amount:** heavy, medium, scanty
- **Color of menses:** bright red, dark red, pale red, red, light purple, dark purple, brown, black
- **Consistency:** thin, watery, dry, thick, sticky, normal, other: _____
- **Clots:** **Number:** none, few, many
 - **Size:** small, medium, large
 - **Color:** fresh red, dark red, pale red, blue, purple, black, other: _____

Period pain:

- **When:** before period, during period, after period, mid-cycle/ovulation
 - # of days in pain each cycle: _____
- **Quality:** dull, sharp, stabbing, cramping, burning, sore, distending, heavy, empty, dragging, other: _____
- **Intensity level 0-10:** _____
- **Location:** low abdomen, groin, ribs, back, legs
- **Reduced by:** warmth, cold, rest, pressure,
- **Made worse by:** warmth, cold, movement, pressure

PMS symptoms:• **Mental/Emotional PMS symptoms:**

- | | | | |
|-------------------------------------|---|---|--|
| <input type="checkbox"/> moodiness | <input type="checkbox"/> irritability | <input type="checkbox"/> anxiety | <input type="checkbox"/> forgetfulness |
| <input type="checkbox"/> depression | <input type="checkbox"/> restlessness | <input type="checkbox"/> clumsiness | <input type="checkbox"/> insomnia |
| <input type="checkbox"/> sadness | <input type="checkbox"/> aggressiveness | <input type="checkbox"/> decreased motivation | <input type="checkbox"/> excess dreaming |
| <input type="checkbox"/> crying | <input type="checkbox"/> outbursts of anger | <input type="checkbox"/> poor concentration | |

• **Physical PMS symptoms:**

- | | | | |
|------------------------------------|---|---|---------------------------------------|
| <input type="checkbox"/> tiredness | <input type="checkbox"/> skin eruptions/pimples | <input type="checkbox"/> nausea | <input type="checkbox"/> feel warmer |
| <input type="checkbox"/> headaches | <input type="checkbox"/> itching | <input type="checkbox"/> vomiting | <input type="checkbox"/> feel colder |
| <input type="checkbox"/> dizziness | <input type="checkbox"/> food cravings | <input type="checkbox"/> breast distension/pain | <input type="checkbox"/> constipation |
| <input type="checkbox"/> edema | <input type="checkbox"/> abdominal distension | <input type="checkbox"/> breast lumps | <input type="checkbox"/> diarrhea |

History of:

- **Urinary tract infections:** how often _____ last occurrence: _____
- **Yeast infections:** how often: _____ last occurrence: _____
- **Vaginal discharge:** how often: _____ last occurrence: _____
 - **Color:** clear, white, yellow, reddish, greenish **Consistency:** watery, thick, dry **Smelly:** yes ___ no ___
 - Vaginal itching Vaginal irritation
- **Sexually transmitted disease (STD):** _____

Reproductive history:

Pregnancies: _____ Cesarean births: _____ # Miscarriages: _____ Age of children: _____

Live births: _____ Vaginal births: _____ # Abortions: _____

Contraceptive pill/ Birth control (what kind): _____ Age used: _____

Hormone replacement therapy (what kind): _____ Age used: _____

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- | | | | |
|------|------|------|------|
| • 1- | • 3- | • 5- | • 7- |
| • 2- | • 4- | • 6- | • 8- |