

DO YOU NOW HAVE, OR HAVE YOU EVER HAD:	YES	NO	?	STAFF COMMENTS
7 Frequent or severe headaches				
8 Seizures/fainting/neurologic disorders				
9 Emotional problems/depression				
10 Vision problems				
11 Chest pain/difficulty breathing				
12 Heart problems/murmurs				
13 High blood fat levels(i.e. cholesterol)				
14 High blood pressure				
15 Blood clots in veins/varicose veins				
16 Anemia/blood disorders				
17 Breast disease/lump/nipple discharge				
18 Stomach/intestinal problems				
19 Gall bladder or liver disease/problems				
20 Kidney/bladder problems/infections				
21 Pain/burning or frequent urination				
22 Frequent vaginal infections				
23 Unusual vaginal discharge/odor				
24 Vaginal itching/burning/rash/bumps				
25 Fever or chills				
26 Lower abdominal pain or pressure				
27 Pain/bleeding with intercourse				
28 Gonorrhea, syphilis, chlamydia, herpes, warts, HIV, AIDS				
29 PID/infection of uterus, tubes, ovaries				
30 Uterine growths/fibroids/abnormality				
31 Abnormal Pap smear				
32 Are you currently sexually active?				First day of last normal period _____
Having more than one sex partner increases the chance of sexual transmitted disease:(STD)				mo day yr
33 How many sex partners have you had in the last 6 months?				How often do you get your period? Every _____ days
34 How many partners has your present partner had in past 6 months?				How many days do you bleed? _____
35 Does your partner(s) have STD symptoms?				Is your bleeding.....___light ___medium___heavy
36 Your age at time of first intercourse _____				Age when your periods began _____
PREGNANCY HISTORY NEVER PREGNANT _____				Unusual or missed periods in past year ___Yes___No
Age at First Pregnancy _____				Severe menstrual cramps ___Yes___No
Number of Living Children _____				Premenstrual discomfort ___Yes___No
Could you be pregnant now? ___yes___no___maybe				Are you currently using birth control? ___Yes___No
Do you have concerns about infertility? YES___NO__				If yes, which method _____
				How long have you used this method? _____
				Problems, if any _____
				Other methods of birth control used: ___Norplant
				___Oral(pill) ___Condom
				___IUD ___Withdrawal
				___Diaphragm ___Depo ___Nuva Ring
				___Foam/cream/suppository/film ___Evra Patch
				___Rhythm/NFP ___Self sterile
				___Partner sterile
				Problems with any of these methods: ___Yes___No
				What method do you want now? _____
RH NEGATIVE ___Yes___No___Unknown				Do you plan to have children in the future?
Toxemia___High Blood Pressure___				___Yes ___No ___Undecided
Diabetes___Other _____				
Any genetic abnormalities___Yes___No				