PRIMARY CARE PHYSICIANS of Gainesville

2019

Menstrual History

(When you are not on birth control pills)

Name: _____ Date of birth: _____ Age: _____

Date of last menstrual period: _____ Date of last pap smear: _____

History of abnormal pap? Yes No If yes, please explain: _____

_____

Age periods began: _____ How many days between periods? _____

How many days of flow? _____ How heavy (# of tampons/pads on heaviest day) _____

How severe are your cramps? _____

Have you bled with sexual intercourse? Yes No Explain: _____

What do you use for contraception? □ Condoms □ Birth Control Pills □ IUD □ Nexplanon

□ None □ Other _____

Number of:	Term Births	Premature Births	Miscarriages or Abortions	Living Children

Personal Medical History

- □ Heart Disease
- □ Headaches
- □ Migraines
- □ Liver Disease
- □ Gallbladder Disease
- □ Blood Clots or Phlebitis
- □ Breast Cancer
- □ Thyroid Disease
- □ Cancer
- □ High Blood Pressure
- □ Diabetes
- □ Acne
- □ Rheumatic Fever
- □ Venereal Disease
- □ Eye Problems
- □ Pelvic Problems
- □ Varicose Veins
- □ Ovarian Cysts
- □ Unusual Vaginal Bleeding
- □ Hepatitis
- □ Herpes: Oral □ Genital □
- □ Sexual Problems
- □ Painful Intercourse