Name:_____Date of Birth:_____Today's Date:_____

In order that we may do a complete evaluation of you, we need the following information. Some of the questions may not apply to your age group. Please circle "yes" or "no" wherever it applies.

1. Have you ever noticed any lumps in your breasts? Yes No
2. Have you ever had discharge from your breasts? Yes No
3. Do you examine your breasts every month? Yes No
4. Have you ever had a mammogram? If yes, when? _____ Yes No
5. Is there a family history of breast, ovarian, uterine or cervical cancer? Yes No
6. Is there a family history of osteoporosis? Yes No
7. Do you have any concerns about your calcium intake? Yes No
8. Have you ever had an abnormal pap smear? If yes, when? _____ Yes No
9. When was your last period? _____
10. Do you have bad cramping with your period? Yes No
11. Do you have unusual breast soreness with your period? Yes No
12. Do you have excessive bloating with your period? Yes No
13. Are you unusually moody or sad before your period? Yes No
14. Do you have any bleeding between periods? Yes No
15. Have your periods changed at all during the last year? If yes, briefly explain_____ Yes No
16. Are you experiencing any hot flashes, vaginal dryness, or mood changes? Yes No
17. Do you ever experience pain with intercourse? Yes No
18. What is your current method of birth control? _____
19. Have any methods of birth control given you difficulty in the past? If yes, which? _____ Yes No
20. Would you like to change your method of birth control? Yes No
21. Do you have any concerns about your sexual relationship? Yes No
22. Do you have any abnormal vaginal itching or discharge? Yes No
23. Have you had a vaginal infection in the last year? Yes No
24. Have you ever had a vaginal or venereal wart? Yes No
25. Have you ever had an infection in your tubes or uterus?(i.e. Pelvic Inflammatory Disease-PID) Yes No
26. Have you had a urinary tract infection in the last year? Yes No
27. Do you notice that you leak urine when you cough, sneeze or laugh? Yes No
28. Have you had any serious illnesses or hospitalizations since your last visit? Yes No

If yes, please explain_____