Lotus Acupuncture & Fertility Clinic

513 N Morrison Rd, Vancouver, WA 98664
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Women's Health History Form

Patient Name: DOB: Visit Date:

Questions about menses

- Have your periods been regular? Yes___, No___
  - If not, were they regular in the past? Yes__, No__
  - Did they change with birth control? Yes__, No__
- How many days is your cycle? _____
- How many days do your period last? ____
- What is the color of your menstrual flow? Dark red___, Bright red__, Other color______
- How much is your menstrual bleeding? Heavy____, scanty____, normal____?
  Quantify Heavy: Menstrual cup_, size of pad ___and how often change them?________
- What is the consistency of your menstrual flow? Is it thin___ thick __ or normal____?
- Are there any clots in your menstrual flow? Yes__, No___. If yes, how big are they_____
- Are there any symptoms or discomfort before, during or after your menses?
  ____

Questions about vaginal discharge

- How has your vaginal discharge been? ________ Is it a lot, scanty or normal _________
- What is the color of your leucorrhea? Is it white, yellow, green, or pus-like? Is there any blood in it? __________________________________
- What is the consistency of your vaginal discharge? Is it thin, sticky, or thick? _________
- Is your vaginal discharge smelly? What is the smell? ____________________________
- Is there any pain, itchy or discomfort in your vulva and vagina? ____________________
- Are there any symptoms accompanied by your vaginal discharge change? ____________
  ____

Question about breast change

- Have you had breast tenderness before your periods? Yes______, No________________
- When was your last mammography? ________Was everything normal? _____________
- Do you notice any discharge from your nipple? Yes______, No________
- Is there skin change of your breasts? Yes ___, No __. If yes, describe it. _____________

Questions about sexual activity and libido

- How has your sexual activity been? _______________________________________
- How has your libido been? Increased? Decreased? ___________________________
- How often do you have intercourse? _______________________________________
- Do you have any pain or discomfort during intercourse? ________________________
- Are you in a monogamous relationship? If so, for how long? _____________________
- Do you currently have sexual transmitted disease? ____________________________
- Have you ever had a STD? When and what was it? ____________________________

Questions about routine medical examinations

- Do you get a yearly routine gynecological examination? Yes____, No____
- When was your last pelvic exam? ___________
- When was your last pap smear? _______ Was it normal? Yes____, No_____

Questions for obstetrics patients
- Do you have a primary care physician (PCP)? Yes___, No____
- How many weeks is your pregnancy? ______
- Do you have any symptoms, spotting or cramps, or discomfort during your pregnancy? ____

In Early pregnancy
- Do you have any morning sickness symptoms? Yes ___, No____
- How many pregnancies have you had? _______
- Do you have a history of miscarriage or high-risk pregnancy? ______________________

Second and third trimester
- Do you see your OBGYN or midwife regularly? Yes__, No____
- How is your blood pressure? ___________________
- How has your urination been? ______ Did your doctor check your urine sample? ______
- Do you have ankle swelling? Yes_______, No______
- Are you anemic? Yes____, No____
- Do you have hemorrhoid? Yes_____, No____
- Do you have varicose veins in your legs? Yes___, No____

History and personal lifestyle
- When did you get your first period? At age ____________________________________
- How many pregnancies have you had? _______________________________________
- How many children do you have?
- Have you previously had a miscarriage or abortion? _____________________________
- When was your last period? ____
- Do you have any family history of breast, ovarian, uterine or other gynecological cancer? If so, who? ____
- Do you drink alcohol? How often? ____________ How much? ___________________
- Do you smoke? ____ Have you ever smoked? ___ For low long? ___How many packs or cigarettes a day? ________
- Do you drink coffee? Yes_, No_. If yes, how much? ____, How often _______________

Is there anything else we should know? ____