

Do you have any abdominal or pelvic pain unrelated to menstruation? Yes () No ()
 Do you ever have any pain with sexual intercourse? Yes () No ()
 Do you have any other complaint, concern or question regarding sex? Yes () No ()
 Do you have any vaginal or vulva irritation, heavy discharge or dryness? Yes () No ()
 Do you frequently have any loss of urine with sneezing and coughing? Yes () No ()
 Do you have frequent night urination, dribbling of urine or bedwetting? Yes () No ()
 Do you have a protrusion or bulging sensation from your vagina? Yes () No ()

OBSTETRIC HISTORY

How many babies born alive? _____ How many Cesarean sections? _____
 How many stillbirths? _____ How many miscarriages or abortions? _____
 How many prematures (less than 5 ½ lbs.) born alive? _____ What is the largest baby's weight? _____
 Have all of your children been normal? Yes () No () My Blood type is _____
 Any serious complications with any pregnancy? If yes, explain: _____

How many living children do you have? _____ Year oldest born: _____ Date of last delivery: _____

MEDICATIONS - Please list your current medications, dosage & frequency

FAMILY HISTORY

	Age	Health	Age at Death	If Deceased, Cause	Has any relative had:	Ck box	If so, who?
Father					Diabetes		
Mother					Heart Disease		
Brother or Sister					High Blood Pressure		
2.					High Cholesterol		
3.					Blood Clots		
4.					Endometriosis		
5.					Cancer - What type?		
Son or Daughter					Relative		Cancer Type
2.					_____		_____
3.					_____		_____
4.					_____		_____
5.					_____		_____