mississippi health center
4631 N. Albina
Portland, OR 97217
(503) 282-5358

WOMEN'S HEALTH HISTORY (2 pages)

Name: _____ Date: ___/____/____

1. Date of last pelvic exam/PAP:_____ Results:_____
   Any past positive PAP?_____
2. OB history: # of pregnancies_____ Date/Type (vag or cesarean) of deliveries_____
3. Please list any pelvic or abdominal surgeries _____
   _____
4. Please list types of birth control/ length of time utilized _____
   _____
5. Menstrual cycle: Date of last menses (day 1 of bleeding)_____ Cycle length (how many days between day 1 of prior menses and day 1 of last menses)_____# of days of bleeding (avg)_____ please circle any combination of the following which applies to you: clots, cramps, mid cycle spotting, purple or black blood, heavy bleeding, fatigue. Any other notable characteristics of your cycle? _____
   _____
   _____
   _____

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6. If you have now, or had in the past, any of the following, please check and explain with dates:

___ low back pain _____
___ menstrual pain _____
___ pain during sex _____
___ PMS _____
___ fibroids/cyst _____
___ hemorrhoids _____
___ pelvic/abdom pain _____
___ prolonged bleeding/altered cycles_____
___ sexually transmitted disease _____
___ hysterectomy _____
___ UTI/bladder infections _____
___ constipation/irritable bowel _____

___ tearing with birth _____

___ endometriosis _____

___ sexual abuse _____

___ depression _____

___ drug abuse _____

___ eating disorder _____

___ childbirth complications_____

___ infertility _____

___ physical or other abuse _____

___ cancer _____

___ smoking habit _____

___ weight issues _____

7. Please write any other pertinent information here: _____

_____

_____

_____