## **Print in Color or Grayscale Only**

Using Adobe Acrobat Reader 8.0 or later

## Women's History

Please answer every question



PLEASE PRINT PATIENT'S LAST NAME						
Marking Instructions						
Please use a # 2 pencil	PLEASE PRINT PATIENT'S FIRST NAME	PATIENT'S DATE O	F BIRTH			
Fill in the complete oval as shown						
		Month Day	Year			

SOCIAL HISTORY				
CAFFEINE	-type(s) of caffeine	coffee 🔾	tea 🔘	soft drinks
		occasionally	0	1-2
	-drink(s) per day	3-4	5-6	7+ 🔾
TOBACCO USE				
How would you describe your cigare	tte smoking?			
currently (every day)	current	ly (some days) 🔘	in the past 🔘	never 🔘
How many packs per day do you (or	did you) smoke?	less than 1	<u> </u>	more than 2 🔘
How many years have you (or did you	u) smoke?	5 or less	─ 6-10 ○	more than 10 🔘
Do you use other tobacco products?		currently 🔘	in the past 🔘	never 🔘
ALCOHOL USE				
Do you consume alcohol?		currently 🔘	in the past 🔘	never 🔘
Average number of drinks per week		7 or less		15 or more 🔘
	ntly 🔵 in the p	oast Onever O	prefer to discu	iss with physician 🔘
History of physical abuse?			ye	s ono o
History of sexual abuse?			ye	s ono o
Occupation:				
Currently sexually active?			ye	s no
Total number of lifetime sexual partners?		ľ	none <10	>10
Planning a pregnancy this year? yes one one				
Current birth control method?				
IUD 🔘			erilization 🔵	abstinence 🔾
IUD (	rhyt	hm hyst	terectomy 🔵	other 🔵
IUD pill foam		hm hyst	terectomy O vasectomy O	other ONONE
IUD pill foam Monthly self breast exams?	rhyt	hm hyst era always	terectomy vasectomy frequently	other NONE never
IUD pill foam	rhyt Depo-prov	hm hystera always bicycling	terectomy ovasectomy frequently running o	other NONE or never swimming
IUD pill foam Monthly self breast exams?	rhyt	hm hystera always bicycling walking	terectomy ovasectomy frequently running aerobics	other NONE or never swimming other
IUD pill foam Monthly self breast exams?	rhyt Depo-prov -type(s) of exercise	hm hystopera laways always bicycling walking occasionally	terectomy ovasectomy frequently running aerobics	other NONE or never swimming other other 1-2
Monthly self breast exams?  EXERCISE	-type(s) of exercise	hm hystopera lalways lalways bicycling walking occasionally 3-4	terectomy orasectomy frequently running aerobics 0 5-6	other NONE y never other other 1-2 7+
IUD pill foam Monthly self breast exams?	rhyt Depo-prov -type(s) of exercise	always occasionally occasionally	terectomy ovasectomy frequently running aerobics	other NONE or never other othe
Monthly self breast exams?  EXERCISE	-type(s) of exercise	hm hystopera lalways lalways bicycling walking occasionally 3-4	terectomy orasectomy frequently running aerobics 0 5-6	other NONE or never other othe
Monthly self breast exams?  EXERCISE	rhyt Depo-prov  -type(s) of exercisetimes per week always	hm hystopera lalways lalways bicycling walking occasionally 3-4	terectomy orasectomy frequently running aerobics 0 5-6	other NONE or never other othe
Monthly self breast exams?  EXERCISE  How often do you wear a seatbelt?  DIAGNOSTIC TESTING / WELLNE	rhyt Depo-prov  -type(s) of exercisetimes per week always	hm hystopera lalways lalways bicycling walking occasionally 3-4	terectomy ovasectomy frequently running aerobics 0 5-6 occasionally	other NONE y never swimming other 1-2 7+ y never
Monthly self breast exams?  EXERCISE  How often do you wear a seatbelt?	rhyt Depo-prov  -type(s) of exercisetimes per week always	hm hystopera lalways lalways bicycling walking occasionally 3-4	terectomy ovasectomy frequently running aerobics 0 5-6 occasionally	other NONE or never other othe
Monthly self breast exams?  EXERCISE  How often do you wear a seatbelt?  DIAGNOSTIC TESTING / WELLNE Have you had an abnormal pap in the	rhyt Depo-prov  -type(s) of exercisetimes per week always <  ESS e last 5 years?	hm hystera always bicycling walking occasionally 3-4 almost always	running aerobics  5-6  occasionally	other NONE y never swimming other 1-2 7+ y never
Monthly self breast exams?  EXERCISE  How often do you wear a seatbelt?  DIAGNOSTIC TESTING / WELLNE Have you had an abnormal pap in the Last pap smear?	rhyt Depo-prov  -type(s) of exercise -times per week always  ESS e last 5 years?	hm hystera always bicycling walking occasionally 3-4 almost always	running aerobics  0 5-6 0 occasionally	other NONE y never swimming other 1-2 7+ y never  never
Monthly self breast exams?  EXERCISE  How often do you wear a seatbelt?  DIAGNOSTIC TESTING / WELLNIE  Have you had an abnormal pap in the  Last pap smear?  Last mammogram?	rhyt Depo-prov  -type(s) of exercise -times per week always  ESS e last 5 years?  NONE   le	always of always occasionally occasionally almost always almost always	running aerobics 0 5-6 0 occasionally n/a ye	other NONE y never swimming other 1-2 7+ y never  nore than 5 years nore than 5 years
Monthly self breast exams?  EXERCISE  How often do you wear a seatbelt?  DIAGNOSTIC TESTING / WELLNE  Have you had an abnormal pap in the  Last pap smear?  Last mammogram?  Last DXA scan (bone density)?	rhyt Depo-prov  -type(s) of exercise -times per week always  ESS e last 5 years?  NONE	always of always	running aerobics  0 5-6 0 occasionally  n/a ye  1-5 years n 1-5 years n 1-5 years n	other NONE y never swimming other 1-2 7+ y never  s no one than 5 years nore than 5 years nore than 5 years
Monthly self breast exams?  EXERCISE  How often do you wear a seatbelt?  DIAGNOSTIC TESTING / WELLNE  Have you had an abnormal pap in the  Last pap smear?  Last mammogram?  Last DXA scan (bone density)?  Last cholesterol level check?	rhyt Depo-prov  -type(s) of exercise -times per week always  ESS e last 5 years?  NONE	always  always  bicycling  walking  occasionally  3-4  almost always  ess than 1 year	running aerobics  0 5-6 0 occasionally  n/a ye  1-5 years n	other NONE y never swimming other 1-2 7+ y never  nore than 5 years
Monthly self breast exams?  EXERCISE  How often do you wear a seatbelt?  DIAGNOSTIC TESTING / WELLNE  Have you had an abnormal pap in the  Last pap smear?  Last pap smear?  Last mammogram?  Last DXA scan (bone density)?  Last cholesterol level check?  Last colonoscopy?	rhyt Depo-prov  -type(s) of exercise -times per week always  ESS e last 5 years?  NONE le NONE le NONE le NONE le NONE le	always  always  bicycling  walking  occasionally  3-4  almost always  ess than 1 year	running aerobics  0 5-6 0 occasionally  n/a years n 1-5 years n	other NONE  y never  swimming other  1-2 7+ y never  nore than 5 years hore than 5 years
Monthly self breast exams?  EXERCISE  How often do you wear a seatbelt?  DIAGNOSTIC TESTING / WELLNE  Have you had an abnormal pap in the  Last pap smear?  Last mammogram?  Last DXA scan (bone density)?  Last cholesterol level check?	rhyt Depo-prov  -type(s) of exercise -times per week always  ESS e last 5 years?  NONE le	always  always  bicycling  walking  occasionally  3-4  almost always  ess than 1 year	running aerobics  0 5-6 0 occasionally  n/a ye  1-5 years n	other NONE y never swimming other 1-2 7+ y never  nore than 5 years

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Using Adobe Acrobat Reader 8.0 or later

## Women's History

Please answer every question



YOUR MEDICAL HISTORY    Please indicate if YOU have a history of any of the following.   (Mork all that apply. If none, mark "NONE.")   anemia		<del></del>				
ansitety disorder GYN cancer (cervical, uterine, ovarian) heumatic fever asthma henart disease sickle cell trait or disease stomach / blowel problems bleeding disorder history of taking antibiotics for dental work breast cancer high cholesterol transfusion(s) chicken pox high blood pressure transfusion(s) diabetes high cholesterol transfusion(s) diabetes epilepsy / seizures   PKU   VAN CHAPPEN   VAN CHAPP						
bleeding disorder history of taking antiblotics for dental work breast cancer high blood pressure thyroid problems cancer high blood pressure high blood pressure thyroid problems transfusion(s) chicken pox hill vexposure varicose veins diabetes liver disease epilepsy / seizures PKU NONE  SURGICAL HISTORY Please indicate if YOU have had any of the following surgeries. (Mark all that apply. If none, mark *1 HAVE HAD NO SURGERIES.*)  I HAVE HAD NO SURGERIES bowel surgery surgery or cervix vaginal injusterectomy bladder surgery ladder surgery ladder surgery vaginal injusterectomy laparoscopies other  FAMILY MEDICAL HISTORY Please indicate if YOUR FAMILY has a history of any of the following. (Only include parents, grandparents, siblings, and children.)  FAMILY HISTORY UNKNOWN tuberculosis ovarian cancer sickle cell disease tracine / endometrial cancer colon cancer ladder stroke colon cancer ladders hipsiblood pressure other  Cesarcan section thyroid disease laddes by real cancer with the following. (Mark all that apply. If none, mark *NONE.*)  FAMILY HISTORY Please indicate if you have a history of any of the following. (Mark all that apply. If none, mark *NONE.*)  GYN HISTORY Please indicate if you have a history of any of the following. (Mark all that apply. If none, mark *NONE.*)  Tumors history please indicate if you have a history of any of the following. (Mark all that apply. If none, mark *NONE.*)  Discovered to the colonia period special period special period special period vaginal discharge genital warts infertility sexual difficulty sexual difficulty spalin bleeding during intercourse bothersome loss of urine urinary problems None  PREGNANCY HISTORY 0 1 2 3 4 5 6 7 8 9 10  Number of toxing and that apply. If none, mark *NONE.*)  pre-term rupture of membrane(s) premature labor other						
bleeding disorder   history of taking antibiotics for dental work   stroke / CVA of the brain   breast cancer   high blood pressure   thyroid problems   thyroid problems   thyroid problems   thyroid problems   transfusion(s)	asthma	heart disease	<ul><li>sickle cell trait or disease</li></ul>			
breast cancer   high blood pressure   thyroid problems   thyroid problems   thyroid problems   thicken pox   high cholesterol   transfusion(s)   thicken pox   high cholesterol   transfusion(s)   thicken pox   high cholesterol   transfusion(s)   thicken pox   high blood pressure   varicose veins   other   other	blood clots		·			
cancer high cholesterol transfusion(s) chicken pox HIV exposure varicose veins depression kidney problems other dabetes liver disease epilepsy / seizures PKU NONE  SURGICAL HISTORY Please indicate if YOU have had any of the following surgeries. (Mark all that apply. If none, mark "1 HAVE HAD NO SURGERIES.")  I HAVE HAD NO SURGERIES bowel surgery rectal surgery rectal surgery surgery on cervix vaginal hysterectomy incontinence surgery vaginal hysterectomy other laborinal hysterectomy of incontinence surgery of any of the following. (Only include parents, grandparents, siblings, and children.)  FAMILY MEDICAL HISTORY Please indicate if YOUR FAMILY has a history of any of the following. (Only include parents, grandparents, siblings, and children.)  FAMILY HISTORY UNKNOWN sickle cell disease uterine / endometrial cancer colon cancer thyroid disease colon cancer stroke colon cancer thyroid disease diabetes high blood pressure other breast cancer NONE  GYN HISTORY Please indicate if you have a history of any of the following. (Mark all that apply. If none, mark "NONE")  Tumors children's genital warts breast cancer waginal infection hill warts infertility sexual difficulty in abnormal pap smear(s) abnormality(les) of the uterus bothersome loss of urine urinary problems  DES exposure (Mark if your mother took DES during pregnancy.) NONE  PREGNANCY HISTORY  Number of transport of abortions (Mark all that apply. If none, mark "NONE.")  premature labor pre-term rupture of membrane(s) helpeding bulbeding beleeding believeling labor pre-term rupture of membrane(s) helpeding bothers other	_					
cesarean section ADOPTED STAMILY HISTORY UNKNOWN ADOPTED Sear section ADOPTED AGAINSTORY ACTION AND SINGE I Stroke Cesarean section ADOPTED ADOPTED ADOPTED AGAINSTORY AGAINSTOR AGAINS						
depression kidney problems oliabetes liver disease epilepsy / seizures PKU  SURGICAL HISTORY Please indicate if YOU have had any of the following surgeries. (Mark all that apply. If none, mark "I HAVE HAD NO SURGERIES.")  I HAVE HAD NO SURGERIES bowel surgery rectal surgery surgery on cervix abdominal hysterectomy incontinence surgery vaginal hysterectomy bladder surgery laparoscopies other  FAMILY MEDICAL HISTORY Please indicate if YOUR FAMILY has a history of any of the following. (Only include parents, grandparents, siblings, and children.)  FAMILY HISTORY UNKNOWN tuberculosis ovarian cancer stroke colon cancer colon cancer colon cancer thyroid disease thyroid disease colotting disorder / hereditary disease diabetes high blood pressure other breast cancer NONE  GYN HISTORY Please indicate if you have a history of any of the following. (Mark all that apply. If none, mark "NONE")  tumors bleeding between periods herpes genital warts infertility sexual difficulty syaphilis abnormal pap smear(s) pain / bleeding during intercourse bothersome loss of urine urinary problems  DES exposure (Mark if your mother took DES during pregnancy.)  Number of pregnancies (include current) 0 1 2 3 4 5 6 7 8 9 10  Number of vaginal deliveries Number of vaginal deliveries Number of dayling dileveries Number of dayling deliveries Number of dayling dileveries Number of abortions Number of abortions Number of ectopics (tubal pregnancy)  Have you had any complications? (Mark all that apply. If none, mark "None.")  pre-term rupture of membrane(s) bleeding brigh blood pressure other			` '			
diabetes   liver disease   epillepsy/ seizures   PKU   NONE	·	•				
SURGICAL HISTORY Please indicate if YOU have had any of the following surgeries. (Mark all that apply. If none, mark "I HAVE HAD NO SURGERIES.")  I HAVE HAD NO SURGERIES	The state of the s		other .			
SURGICAL HISTORY  Please indicate if YQU have had any of the following surgeries. (Mark all that apply. If none, mark "I HAVE HAD NO SURGERIES.")  I HAVE HAD NO SURGERIES  cesarean section abdominal hysterectomy bladder surgery laparoscopies  FAMILY MEDICAL HISTORY  Please indicate if YQUR FAMILY has a history of any of the following. (Only include parents, grandparents, siblings, and children.)  FAMILY HISTORY UNKNOWN ADOPTED  sickle cell disease cesarean section diabetes high blood pressure heart attack  breast cancer  NONE  GYN HISTORY  Please indicate if you have a history of any of the following. (Mark all that apply. If none, mark "NONE.")  tumors bleeding between periods herpes vaginal discharge genital warts yaginal infection yaginal infection abnormal pap smear(s) genorrhea abnormal pap smear(s) genorrhea abnormality(ies) of the uterus breast cancer  NONE  PREGNANCY HISTORY  Number of pregnancies (include current) Number of pregnancies (include current) Number of pregnancies (include current) Number of vaginal deliveries Number of vaginal deliveries Number of vaginal deliveries Number of vaginal deliveries Number of pregnancies (tubal pregnancy)  Have you had any complications? (Mark all that apply. If none, mark "NONE.") pre-term rupture of membrane(s) bleeding high blood pressure pre-term rupture of membrane(s) bleeding high blood pressure other pre-term rupture of membrane(s) bleeding high blood pressure other other predictions of the dometrial cancer colon cancer clothing during intercourse bloeding on the following. Arabitatory of the uterus bleeding on the following. Arabitatory of any of the following. Arabitatory of any of the following. Arabitatory of any of the following. Interiblity sexual difficulty sexual d			NONE			
(Mark all that apply. If none, mark "I HAVE HAD NO SURGERIES.")  I HAVE HAD NO SURGERIES   bowel surgery   rectal surgery   surgery on cervix   subdominal hysterectomy   incontinence surgery   vaginal hysterectomy   bladder surgery   laparoscopies   other  FAMILY MEDICAL HISTORY   Please indicate if YOUR FAMILY has a history of any of the following. (Only include parents, grandparents, siblings, and children.)  FAMILY HISTORY UNKNOWN   tuberculosis   ovarian cancer   ADOPTED   sickle cell disease   uterine / endometrial cancer   colon cancer   thyroid disease   colon cancer   other   heart attack   breast cancer   NONE  GYN HISTORY   Please indicate if you have a history of any of the following. (Mark all that apply. If none, mark "NONE.")  Tumors   chlamydia   severe pain during period   the pressure   the pressure   cyst(s) of the ovary(ies)   vaginal discharge   genital warts   infertility   sexual difficulty   syphilis   abnormal pap smear(s)   abnormal pap smear(s)   pain / bleeding during intercourse   bothersome loss of urine   trichomonas   DES exposure (Mark if your mother took DES during pregnancy.)  PREGNANCY HISTORY   Number of Pregnancies (include current)   Number of expositions   Number of measurings   Number of membrane(s)   bleeding   high blood pressure   other   other   other	cpiicpsy/ scizures		O NONE			
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cesarean section   colon surgery   surgery on cervix   abdominal hysterectomy   laparoscopies   other    FAMILY MEDICAL HISTORY   Please indicate if YOUR FAMILY has a history of any of the following.	I HAVE HAD NO SURGERIES	bowel surgery	rectal surgery			
PAMILY MEDICAL HISTORY		colon surgery	surgery on cervix			
FAMILY MEDICAL HISTORY    Please indicate if YOUR FAMILY has a history of any of the following. (Only include parents, grandparents, siblings, and children.)   FAMILY HISTORY UNKNOWN   tuberculosis   ovarian cancer   ovarian ca	·		=			
(Only include parents, grandparents, siblings, and children.)  FAMILY HISTORY UNKNOWN ADOPTED Sickle cell disease Stroke Colon cancer Cesarean section Cesarean	bladder surgery	laparoscopies	other			
(Only include parents, grandparents, siblings, and children.)  FAMILY HISTORY UNKNOWN ADOPTED Sickle cell disease Stroke Colon cancer cesarean section Cesarean secter Cesarean section Cesarean						
ADOPTED sickle cell disease uterine / endometrial cancer colon cancer clothe cancer clothe cancer clothe cancer high blood pressure bheart attack breast cancer NONE  GYN HISTORY  Please indicate if you have a history of any of the following. (Mark all that apply. If none, mark "NONE.")  tumors chlamydia severe pain during period bleeding between periods herpes cyst(s) of the ovary(ies) infertility synali infection HIV synali infection spain / bleeding during intercourse gonorrhea abnormality(ies) of the uterus bothersome loss of urine trichomonas severe cramping urinary problems  DES exposure (Mark if your mother took DES during pregnancy.)  Number of pregnancies (include current) Number of vaginal deliveries Number of abortions Number of abortions Number of abortions Number of abortions (Mark all that apply. If none, mark "NONE.")  Preterm rupture of membrane(s) other other other of here on the other of the other ot						
cesarean section thyroid disease clotting disorder / hereditary disease diabetes heart attack breast cancer NONE  GYN HISTORY Please indicate if you have a history of any of the following. (Mark all that apply. If none, mark "NONE.")  tumors chlamydia severe pain during period cyst(s) of the ovary(ies) infertility vaginal discharge genital warts infertility sexual difficulty syphilis abnormal pap smear(s) pain / bleeding during intercourse bothersome loss of urine trichomonas severe cramping urinary problems  DES exposure (Mark if your mother took DES during pregnancy.)  PREGNANCY HISTORY  Number of pregnancies (include current) Number of vaginal deliveries Number of dive births Number of of socious humber of abortions Number of abortions Number of ectopics (tubal pregnancy) Have you had any complications? (Mark all that apply. If none, mark "NONE.") premature labor pre-term rupture of membrane(s) other other other of the premature labor other ot	FAMILY HISTORY UNKNOW	/N tuberculosis	ovarian cancer			
cesarean section thyroid disease diabetes high blood pressure other heart attack breast cancer NONE  GYN HISTORY  Please indicate if you have a history of any of the following. (Mark all that apply. If none, mark "NONE.")  tumors chlamydia severe pain during period bleeding between periods herpes cyst(s) of the ovary(ies) infertility vaginal discharge genital warts infertility syphilis abnormal pap smear(s) pain / bleeding during intercourse bothersome loss of urine trichomonas severe cramping urinary problems  DES exposure (Mark if your mother took DES during pregnancy.)  PREGNANCY HISTORY  Number of pregnancies (include current) Number of vaginal deliveries Number of abortions Number of ectopics (tubal pregnancy)  Have you had any complications? (Mark all that apply. If none, mark "NONE.") premature labor pre-term rupture of membrane(s) bleeding high blood pressure	○ ADOPTED	sickle cell disease	uterine / endometrial cancer			
diabetes high blood pressure breast cancer NONE    GYN HISTORY   Please indicate if you have a history of any of the following. (Mark all that apply. If none, mark "NONE.")    tumors   chlamydia   severe pain during period   bleeding between periods   herpes   cyst(s) of the ovary(ies)   vaginal discharge   genital warts   infertility   synhilis   abnormal pap smear(s)   pain / bleeding during intercourse   source cramping   urinary problems   DES exposure (Mark if your mother took DES during pregnancy.)   NONE    PREGNANCY HISTORY   0 1 2 3 4 5 6 7 8 9 10   Number of pregnancies (include current)   Number of vaginal deliveries   Number of csections   Number of miscarriages   Number of abortions   Number of miscarriages   Number of ectopics (tubal pregnancy)   Have you had any complications? (Mark all that apply. If none, mark "NONE.")   pre-term rupture of membrane(s)   bleeding   high blood pressure   other o						
heart attack breast cancer NONE  GYN HISTORY Please indicate if you have a history of any of the following.  (Mark all that apply. If none, mark "NONE.")  tumors chlamydia severe pain during period bleeding between periods herpes cyst(s) of the ovary(ies) vaginal discharge genital warts infertility vaginal infection HIV sexual difficulty syphilis abnormal pap smear(s) pain / bleeding during intercourse gonorrhea abnormality(ies) of the uterus bothersome loss of urine trichomonas severe cramping urinary problems DES exposure (Mark if your mother took DES during pregnancy.)  NONE  PREGNANCY HISTORY  Number of pregnancies (include current) Number of live births Number of csections Number of ectopics (tubal pregnancy) Have you had any complications? (Mark all that apply. If none, mark "NONE.") breech premature labor pre-term rupture of membrane(s) bleeding high blood pressure or the following. Other of the order of any of the following. None  N						
GYN HISTORY  Please indicate if you have a history of any of the following.  (Mark all that apply. If none, mark "NONE.")  tumors  chlamydia  severe pain during period  cyst(s) of the ovary(ies)  vaginal discharge  genital warts  infertility  sexual difficulty  sexual difficulty						
(Mark all that apply. If none, mark "NONE.")  tumors	heart attack	breast cancer	NONE			
tumors chlamydia severe pain during period bleeding between periods herpes cyst(s) of the ovary(ies) vaginal discharge genital warts infertility vaginal infection HIV sexual difficulty syphilis abnormal pap smear(s) pain / bleeding during intercourse gonorrhea abnormality(ies) of the uterus bothersome loss of urine trichomonas severe cramping urinary problems  DES exposure (Mark if your mother took DES during pregnancy.)  NONE  PREGNANCY HISTORY  Number of pregnancies (include current)  Number of vaginal deliveries  Number of vaginal deliveries  Number of G-sections  Number of abortions  Number of abortions  Number of ectopics (tubal pregnancy)  Have you had any complications? (Mark all that apply. If none, mark "NONE.")  breech premature labor pre-term rupture of membrane(s)  bleeding high blood pressure						
bleeding between periods herpes cyst(s) of the ovary(ies) vaginal discharge genital warts infertility vaginal infection HIV sexual difficulty syphilis abnormal pap smear(s) pain / bleeding during intercourse gonorrhea abnormality(ies) of the uterus bothersome loss of urine trichomonas severe cramping urinary problems DES exposure (Mark if your mother took DES during pregnancy.)  NONE  PREGNANCY HISTORY  O 1 2 3 4 5 6 7 8 9 10  Number of pregnancies (include current) Number of live births Number of vaginal deliveries Number of C-sections Number of abortions Number of abortions Number of ectopics (tubal pregnancy) Have you had any complications? (Mark all that apply. If none, mark "NONE.") breech premature labor pre-term rupture of membrane(s) bleeding high blood pressure		(Mark all that apply. If none, mai	rk "NONE.")			
vaginal discharge genital warts infertility sexual difficulty sexual difficulty syphilis abnormal pap smear(s) pain / bleeding during intercourse bothersome loss of urine trichomonas severe cramping urinary problems DES exposure (Mark if your mother took DES during pregnancy.)  PREGNANCY HISTORY  Number of pregnancies (include current) Number of vaginal deliveries Number of vaginal deliveries Number of esections Number of abortions Number of ectopics (tubal pregnancy) Have you had any complications? (Mark all that apply. If none, mark "NONE.") breech premature labor pre-term rupture of membrane(s) bleeding high blood pressure		chlamydia				
vaginal infection	= -	·				
syphilis abnormal pap smear(s) pain / bleeding during intercourse gonorrhea abnormality(ies) of the uterus bothersome loss of urine urinary problems  DES exposure (Mark if your mother took DES during pregnancy.)  NONE  PREGNANCY HISTORY  Number of pregnancies (include current)  Number of vaginal deliveries  Number of vaginal deliveries  Number of miscarriages  Number of abortions  Number of ectopics (tubal pregnancy)  Have you had any complications? (Mark all that apply. If none, mark "NONE.")  breech premature labor pre-term rupture of membrane(s)  bleeding high blood pressure		=	•			
gonorrhea abnormality(ies) of the uterus bothersome loss of urine trichomonas severe cramping urinary problems  DES exposure (Mark if your mother took DES during pregnancy.)  NONE  PREGNANCY HISTORY  O 1 2 3 4 5 6 7 8 9 10  Number of pregnancies (include current)  Number of live births  Number of vaginal deliveries  Number of C-sections  Number of miscarriages  Number of abortions  Number of ectopics (tubal pregnancy)  Have you had any complications? (Mark all that apply. If none, mark "NONE.")  breech premature labor pre-term rupture of membrane(s)  bleeding high blood pressure	_		· · · · · · · · · · · · · · · · · · ·			
trichomonas severe cramping urinary problems DES exposure (Mark if your mother took DES during pregnancy.)  PREGNANCY HISTORY  Number of pregnancies (include current) Number of live births Number of vaginal deliveries Number of c-sections Number of miscarriages Number of abortions Number of ectopics (tubal pregnancy) Have you had any complications? (Mark all that apply. If none, mark "NONE.") breech premature labor pre-term rupture of membrane(s) bleeding high blood pressure						
PREGNANCY HISTORY    Number of pregnancies (include current)						
PREGNANCY HISTORY    O   1   2   3   4   5   6   7   8   9   10			* *			
Number of pregnancies (include current)  Number of live births  Number of vaginal deliveries  Number of C-sections  Number of miscarriages  Number of abortions  Number of ectopics (tubal pregnancy)  Have you had any complications? (Mark all that apply. If none, mark "NONE.")  breech premature labor pre-term rupture of membrane(s)  bleeding high blood pressure	programmy year means took and programmy,					
Number of live births Number of vaginal deliveries Number of C-sections Number of miscarriages Number of abortions Number of ectopics (tubal pregnancy) Have you had any complications? (Mark all that apply. If none, mark "NONE.") breech premature labor pre-term rupture of membrane(s) bleeding high blood pressure	PREGNANCY HISTORY	0 1 2 3	4 5 6 7 8 9 10			
Number of vaginal deliveries  Number of C-sections  Number of miscarriages  Number of abortions  Number of ectopics (tubal pregnancy)  Have you had any complications? (Mark all that apply. If none, mark "NONE.")  breech premature labor pre-term rupture of membrane(s)  bleeding high blood pressure						
Number of C-sections Number of miscarriages Number of abortions Number of ectopics (tubal pregnancy) Have you had any complications? (Mark all that apply. If none, mark "NONE.") breech premature labor pre-term rupture of membrane(s) bleeding high blood pressure						
Number of miscarriages  Number of abortions  Number of ectopics (tubal pregnancy)  Have you had any complications? (Mark all that apply. If none, mark "NONE.")  breech premature labor pre-term rupture of membrane(s)  bleeding high blood pressure other						
Number of abortions Number of ectopics (tubal pregnancy) Have you had any complications? (Mark all that apply. If none, mark "NONE.") breech premature labor pre-term rupture of membrane(s) bleeding high blood pressure other						
Number of ectopics (tubal pregnancy)  Have you had any complications? (Mark all that apply. If none, mark "NONE.")  breech premature labor pre-term rupture of membrane(s)  bleeding high blood pressure other						
Have you had any complications? (Mark all that apply. If none, mark "NONE.")  breech premature labor pre-term rupture of membrane(s)  bleeding high blood pressure other						
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bleeding high blood pressure other						
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