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GYNECOLOGICAL HISTORY

Name: _____

Date: _____

Any current concerns? _____

Date of last Gyn exam and pap smear:

Any difficulty with previous exams?

Age of onset of menses: _____

First day of last menstrual period: _____

Was it normal? _____

What is normal for you? _____

Any problems with periods? (pain, PMS,
heavy bleeding, irregularity, bleeding in
between cycles?) _____

Number of days between first day of one
period and first day of next: _____

Do regular self breast exams? _____

Pain with sexual activity? _____

Number of male partners in last 3 years?

Birth Control History

Currently using what method of birth
control? _____

Used in past: (please include dates)

Birth Control Pills _____

- What kind? _____

IUD: _____

- What kind? _____

Diaphragm _____

Cervical Cap _____

- What kind? _____

Sponges _____

Condoms _____

Foam _____

Other _____

Any problems or benefits encountered?

Any hormone medications used?

(Provera, estrogen preplacement, DES,
"morning after pill", anabolic steroids, cortisone
or prednisone, thyroid medicines)

Any other medications? _____

Pregnancy History

Pregnant now? _____ #of weeks? _____

Number of pregnancies: _____

Births _____ Miscarriages _____

Abortions? _____ Tubal/ectopic _____

Any difficulty conceiving? _____

Any complications of pregnancy?

(hemorrhage, infection, C-section, toxemia, blood sugar or blood pressure problems) _____

Medical History

(Include dates and treatment)

Abnormal pap smear? _____

Cancer? _____

Thyroid Problems? _____

Venereal Warts? _____

Vaginal infections? _____

Bleeding/clotting problems? _____

Chlamydia, Gonorrhea or Syphilis? _____

Herpes? _____

Pelvic Inflammatory Disease? _____

Uterine/cervical abnormalities? _____

Ovarian cysts/tumors? _____

Anemia? _____

Diabetes? _____

Breast lumps/tumors? _____

Nipple discharge? _____

Bladder infections? _____

Uterine fibroids, endometriosis? _____

Any surgeries/hospitalizations? _____

Anything else?
