This form covers ways we may be of help to you. Please, fill in the blanks and circle Yes or No.

The main reason you are here to see me today is: _____

What was the first day of your last menstrual period? _____/_____/_____

When was your last pap smear? _____/_____/_____ Normal? Yes… No

1. Are your periods irregular?……. Yes..No

2. Are your periods painful?……...…….Yes..No

3. Do you bleed between periods?…..…… Yes..No

4. Do you bleed after sex or douching?……...……Yes..No

5. Is sexual activity painful?……...……Yes..No

6. Do you have problems prior to starting a period?……...…… Yes..No

7. Are you frequently tired or fatigued?…….. Yes..No

8. Are you troubled with a discharge?…...……..Yes..No

9. Is there itching and/or burning?…….……..Yes..No

10. Have you had an infection of your tubes/ovaries?……..……...Yes..No

11. Do you ever lose control of your bladder?…… Yes..No

12. Do you ever lose urine with laughter or a cough?…….……Yes..No

13. Is there ever blood in your urine?……..Yes..No

14. Do you ever feel that something is pushing out?……...Yes..No

15. Do you do self breast exam regularly?…….. Yes..No

16. Have you noticed any breast lumps?…….Yes..No

17. Have you had any blood or fluid from your breasts?…… Yes..No

18. Have you had problems with diarrhea?…….Yes..No

19. Have you had problems with constipation?……..…….Yes..No

20. Do you ever have bloody or black stools?……...…..Yes..No

Please, sign your name here: _____