

Pregnancy History

Number of Pregnancies ____ Date(s) ____ Miscarriage(s) ____ Dates ____ Termination(s) ____ Dates ____

Number of Births ____ Date(s) ____

Complications for any of the above? Describe: _____

Premature births? ____ Spotting during pregnancy? ____ Weak newborns? ____ Incompetent cervix? ____

Describe your experience with

Pregnancy _____

Labor _____

Birthing _____

Postpartum _____

Maternal Family History of (please circle) Infertility Fibroids Endometriosis PMS Menopause

Cancer (type) _____ Menstrual problems _____ Other _____

Medications your mother took when she was pregnant with you (if any) _____

Your birth trauma (if known) _____

Menopause

Age symptoms began ____ Are they getting worse? ____ Better? ____ Same? ____

Are you taking or have you ever taken hormone replacement therapy? ____ If so, for how long? ____

Name and dosage _____

Reason for stopping _____

Age of mother at menopause: ____ Concerns/experience _____

Check the following symptoms that apply to you:

- | | | | | |
|-------------------|-------------------------|------------------|---------------------|------------------|
| Hot flashes | Insomnia | Fatigue | Memory loss | Mood swings |
| Vaginal discharge | Dry vagina | Depression | Anxiety | Irritability |
| Spotting | Flooding | Irregular menses | Painful intercourse | Increased libido |
| Decreased libido | Disturbed sleep pattern | | | |

Additional Information you feel important your practitioner should know that is not mentioned here:

