



Lifecycles Wellness
Gynecology Intake Form
lifecycleswellness.com 647.428.7200

Gynecology Health History

Name: _____ Date: _____

What is the gynecological concern for which you are seeking treatment?

Age of your first menstrual cycle? _____

Are your periods painful? _____ How many days does the pain last? _____

How many days do you usually bleed? _____ How heavy? _____

What color is the blood? ___ light red ___ red ___ dark red ___ purple ___ brown

Is there clotting? _____

What are your premenstrual symptoms? _____

Do you get acne breakouts before or during your period? _____

Do your breasts become tender premenstrually? _____

How many days from one period to the next? _____ Date of last period _____

Have your cycles changed since they began? _____

Do you get yeast infections regularly? _____

Date of last pap smear _____ Have you had an abnormal pap smear? _____

Have you had a cervical biopsy, operation or cauterization? _____

Have you been diagnosed with uterine fibroids? _____ endometriosis? _____

Date of last mammogram _____ Have you had an abnormal mammogram? _____

Do you do a monthly breast self-exam?

What types of contraception do you or have you used in the past? How long did you use each?

Between periods, how much discharge do you have, if any? _____

Is it thin or thick? _____ Does it have a color? _____ An odor? _____

How many pregnancies have you had? _____ How many children do you have? _____

Have you had an abortion? _____ Miscarriage? _____ D&C? _____

Menopause (please answer if applicable)

When did you notice your periods starting to change? _____

Date of last period _____

What symptoms, if any, did you experience during perimenopause?

Please be assured that your information is confidential and will be shared only with your practitioners.