Women's Health Gynecological History Form

Personal Information

Full Name

Date of Birth

Phone Number

Email Address

Gynecological History

Age at first period

Date of last period

Are your periods regular?

- Yes
- No

If no, please explain

Cycle length (days)

Bleeding duration (days)

Any bleeding between periods?

- Yes
- No

Pain with periods?

- Yes
- No

If yes, severity or comments

Obstetric History

Number of pregnancies

Number of births

Number of miscarriages

Number of abortions

Any complications?

Contraception & Sexual Health

Current contraception method

Are you sexually active?

- Yes
- No

History of sexually transmitted infections (STIs)?

- Yes
- No

If yes, details

Medical History

Previous gynecological surgeries or procedures

Any known gynecological conditions? (e.g., endometriosis, fibroids, PCOS)

Last Pap smear date

Last mammogram date

Other relevant medical history

Family History

Family history of reproductive cancers?

- Yes
- No

If yes, please specify

Other relevant family history

Comments / Additional Information