

Westwood Women's Health Member of Women's Health Connecticut Mark S. DeFrancesco, MD Melissa M. Pearlstone, MD Mark R. Preston, MD 60 Westwood Avenue Suite 200 Waterbury, CT 06708 203-574-5501

Significance by Birthdate evou here for a problem?	ame	Date
ve you consulted anyone for this?	ferred by	Birthdate
ve you consulted anyone for this?	*	
cribe previous treatment N SYSTEM REVIEW: Date of last period Menses: Age at onset of period: Date of last pap smear Irregular Regular How often do you get your period? (Check appropriate box below) Less than 20 days apart 21-30 days apart 30-40 days apart Greater than 40 days apart How many days do your periods generally last? (Check appropriate box below) Less than 2 2-5 5-7 7-10 Greater than 10 How many pads do you use on heaviest days? Do you use Pads or Tampax Scented? Yes No Any clots? How large? Do you have to stay in bed on heavy days? Do you have or stay in bed on heavy days? Any bleeding or sporting between periods? Any bleeding or sporting after intercourse? N: Do you have any significant pain with periods? Do you have any lower abdominal pain at other times of the month? If yes, how many dayse intercourse? Do you have pain during or after intercourse? Do you have pain during or after intercourse? Do you have pany lower abdominal pain at other times of the month? If yes to any of the above: Describe location, character, radiation or distribution, frequency and duration of any of the above answers:		
crib (Dates of treatment) cribe previous treatment N SYSTEM REVIEW: Date of last period Menses: Age at onset of period: Irregular Regular How often do you get your period? (Check appropriate box below) Less than 20 days apart 21 - 30 days apart 30 - 40 days apart Greater than 40 days apart How many days do your periods generally last? (Check appropriate box below) Less than 2 2 - 5 5 - 7 7 - 10 Greater than 10 How many pads do you use on heaviest days? Do you use Pads or Tampax Scented? Yes No Any clots? How large? Do you have to stay in bed on heavy days? Do you miss work or school regularly each month? If yes, how many days? Any bleeding or sporting between periods? Any bleeding or sporting between periods? Any bleeding or sporting after intercourse? No Do you have any significant pain with periods? Do you have any lower abdominal pain at other times of the month? Do you have pain during or after intercourse? Do you have pain during or after intercourse? Do you have pain during or after intercourse? Do you have frequent headaches? If yes to any of the above: Describe location, character, radiation or distribution, frequency and duration of any of the above: Describe location, character, radiation or distribution, frequency and duration of any of the above: Describe location, character, radiation or distribution, frequency and duration of any of the above: Describe location, character, radiation or distribution, frequency and duration of any of the above: Describe location, character, radiation or distribution, frequency and duration of any of the above: Describe location, character, radiation or distribution, frequency and duration of any of the above: Describe location, character, radiation or distribution, frequency and duration of any of the above: Describe location, character, radiation or distribution, frequency and duration of any of the above: Describe location, character, radiation or distribution, frequency and duration of any		
Date of last period	o? (Name and Address)	·
Date of last period	en? (Dates of treatment)	
Date of last period Menses: Age at onset of period: Date of last pap smear Irregular Regular How often do you get your period? (Check appropriate box below) Less than 20 days apart 21 - 30 days apart 30 - 40 days apart Greater than 40 days apart How many days do your periods generally last? (Check appropriate box below) Less than 2 2-5 5-7 7-10 Greater than 10 How many pads do you use on heaviest days? Do you use Pads or Tampax Scented? Yes No Any clots? How large? Do you have to stay in bed on heavy days? Do you miss work or school regularly each month? If yes, how many days? Any bleeding or sporting between periods? Any bleeding or sporting after intercourse? No Do you have any significant pain with periods? Do you have any hower abdominal pain at other times of the month? Do you have frequent headaches? If yes to any of the above: Describe location, character, radiation or distribution, frequency and duration of any of the above answers:		
Menses: Age at onset of period: Irregular Regular How often do you get your period? (Check appropriate box below) Less than 20 days apart 21 - 30 days apart 30 - 40 days apart Greater than 40 days apart How many days do your periods generally last? (Check appropriate box below) Less than 2 2 - 5 5 - 7 7 - 10 Greater than 10 How many pads do you use on heaviest days? Do you use Pads or Tampax Scented? Yes No Any clots? How large? Do you have to stay in bed on heavy days? Do you miss work or school regularly each month? If yes, how many days? Any bleeding or sporting between periods? Any bleeding or sporting after intercourse? Do you have any significant pain with periods? Do you have any significant pain with periods? Do you have pain during or after intercourse? Do you have frequent headaches? If yes to any of the above: Describe location, character, radiation or distribution, frequency and duration of any of the above answers:		
Menses: Age at onset of period: Irregular Regular How often do you get your period? (Check appropriate box below) Less than 20 days apart 21 - 30 days apart 30 - 40 days apart Greater than 40 days apart How many days do your periods generally last? (Check appropriate box below) Less than 2 2 - 5 5 - 7 7 - 10 Greater than 10 How many pads do you use on heaviest days? Do you use Pads or Tampax Scented? Yes No Any clots? How large? Do you have to stay in bed on heavy days? Do you miss work or school regularly each month? If yes, how many days? Any bleeding or sporting between periods? Any bleeding or sporting after intercourse? Do you have any significant pain with periods? Do you have any significant pain with periods? Do you have pain during or after intercourse? Do you have frequent headaches? If yes to any of the above: Describe location, character, radiation or distribution, frequency and duration of any of the above answers:	Date of last period	
Irregular Regular How often do you get your period? (Check appropriate box below) Less than 20 days apart 21 - 30 days apart 30 - 40 days apart Greater than 40 days apart How many days do your periods generally last? (Check appropriate box below) Less than 2 2-5 5-7 7-10 Greater than 10		
Less than 20 days apart	☐ Irregular ☐ Regular	
☐ Less than 20 days apart ☐ 21 - 30 days apart ☐ 30 - 40 days apart ☐ Greater than 40 days apart How many days do your periods generally last? (Check appropriate box below) ☐ Less than 2 ☐ 2 - 5 ☐ 5 - 7 ☐ 7 - 10 ☐ Greater than 10 ☐ How many pads do you use on heaviest days? ☐ Do you use ☐ Pads or ☐ Tampax ☐ Scented? ☐ Yes ☐ No ☐ Any clots? ☐ How large? ☐ Do you have to stay in bed on heavy days? ☐ Do you miss work or school regularly each month? ☐ If yes, how many days? ☐ Any bleeding or sporting between periods? ☐ Any bleeding or sporting after intercourse? ☐ Do you have any significant pain with periods? ☐ Do you have any lower abdominal pain at other times of the month? ☐ Do you have frequent headaches? ☐ Do you have frequent headaches? ☐ If yes to any of the above: Describe location, character, radiation or distribution, frequency and duration of any othe above answers:	How often do you get your period? (Check appropriate box below	w)
How many days do your periods generally last? (Check appropriate box below) Less than 2 2-5 5-7 7-10 Greater than 10 How many pads do you use on heaviest days? Do you use Pads or Tampax Scented? Yes No YES NO Any clots? How large? Do you have to stay in bed on heavy days? Do you miss work or school regularly each month? If yes, how many days? Any bleeding or sporting between periods? Any bleeding or sporting after intercourse? IN: Do you have any significant pain with periods? Do you have any lower abdominal pain at other times of the month? Do you have pain during or after intercourse? If yes to any of the above: Describe location, character, radiation or distribution, frequency and duration of any of the above answers:		•
□ Less than 2 □ 2 - 5 □ 5 - 7 □ 7 - 10 □ Greater than 10 How many pads do you use on heaviest days? □Do you use □ Pads or □ Tampax Scented? □ Yes □ No YES NO Any clots? □How large? □Do you have to stay in bed on heavy days? □Do you miss work or school regularly each month? □If yes, how many days? □Any bleeding or sporting between periods? Any bleeding or sporting after intercourse? □Do you have any significant pain with periods? □Do you have any lower abdominal pain at other times of the month? □Do you have pain during or after intercourse? □Do you have frequent headaches? □Do you have frequent headaches? □If yes to any of the above: Describe location, character, radiation or distribution, frequency and duration of any of the above answers:		
How many pads do you use on heaviest days?		
Do you use Pads or Tampax Scented? Yes No Any clots?	LESS THAN Z LIZED LICETEASTER th	200 10
Any clots?		
Any clots? How large? Do you have to stay in bed on heavy days? Do you miss work or school regularly each month? If yes, how many days? Any bleeding or sporting between periods? Any bleeding or sporting after intercourse? IN: Do you have any significant pain with periods? Do you take any medication to relieve it regularly? Do you have any lower abdominal pain at other times of the month? Do you have pain during or after intercourse? Do you have frequent headaches? If yes to any of the above: Describe location, character, radiation or distribution, frequency and duration of any of the above answers:	How many pads do you use on heaviest days?	
How large? Do you have to stay in bed on heavy days? Do you miss work or school regularly each month? If yes, how many days? Any bleeding or spotting between periods? Any bleeding or spotting after intercourse? Do you have any significant pain with periods? Do you take any medication to relieve it regularly? Do you have any lower abdominal pain at other times of the month? Do you have pain during or after intercourse? Do you have frequent headaches? If yes to any of the above: Describe location, character, radiation or distribution, frequency and duration of any of the above answers:	How many pads do you use on heaviest days?	es 🗆 No
Do you have to stay in bed on heavy days? Do you miss work or school regularly each month? If yes, how many days? Any bleeding or spotting between periods? Any bleeding or spotting after intercourse? Do you have any significant pain with periods? Do you take any medication to relieve it regularly? Do you have any lower abdominal pain at other times of the month? Do you have pain during or after intercourse? Do you have frequent headaches? If yes to any of the above: Describe location, character, radiation or distribution, frequency and duration of any of the above answers:	How many pads do you use on heaviest days? Do you use Pads or Tampax Scented? Ye	es □ No YES NO
Do you miss work or school regularly each month? If yes, how many days? Any bleeding or sporting between periods? Any bleeding or sporting after intercourse? Do you have any significant pain with periods? Do you take any medication to relieve it regularly? Do you have any lower abdominal pain at other times of the month? Do you have pain during or after intercourse? Do you have frequent headaches? If yes to any of the above: Describe location, character, radiation or distribution, frequency and duration of any of the above answers:	How many pads do you use on heaviest days? Do you use Pads or Tampax Scented? Ye Any clots?	es □ No YES NO
If yes, how many days? Any bleeding or spotting between periods? Any bleeding or spotting after intercourse? Do you have any significant pain with periods? Do you take any medication to relieve it regularly? Do you have any lower abdominal pain at other times of the month? Do you have pain during or after intercourse? Do you have frequent headaches? If yes to any of the above: Describe location, character, radiation or distribution, frequency and duration of any of the above answers:	How many pads do you use on heaviest days? Do you use Pads or Tampax Scented? Ye Any clots?	es □ No YES NO
Any bleeding or spotting between periods? Any bleeding or spotting after intercourse? Do you have any significant pain with periods? Do you take any medication to relieve it regularly? Do you have any lower abdominal pain at other times of the month? Do you have pain during or after intercourse? Do you have frequent headaches? If yes to any of the above: Describe location, character, radiation or distribution, frequency and duration of any of the above answers:	How many pads do you use on heaviest days? Do you use Pads or Tampax Scented? Ye Any clots? How large? Do you have to stay in bed on heavy days?	es □ No YES NO
Any bleeding or spotting after intercourse? Do you have any significant pain with periods? Do you take any medication to relieve it regularly? Do you have any lower abdominal pain at other times of the month? Do you have pain during or after intercourse? Do you have frequent headaches? If yes to any of the above: Describe location, character, radiation or distribution, frequency and duration of any of the above answers:	How many pads do you use on heaviest days? Do you use Pads or Tampax Scented? Ye Any clots? How large? Do you have to stay in bed on heavy days? Do you miss work or school regularly each month? If yes, how many days?	es □ No YES NO
Do you have any significant pain with periods?	How many pads do you use on heaviest days?	es D No YES NO
Do you take any medication to relieve it regularly?	How many pads do you use on heaviest days?	es D No YES NO
Do you take any medication to relieve it regularly?	How many pads do you use on heaviest days?	es I No YES NO
Do you have any lower abdominal pain at other times of the month?	How many pads do you use on heaviest days? Do you use Pads or Tampax Scented? Yee Any clots? How large? Do you have to stay in bed on heavy days? Do you miss work or school regularly each month? If yes, how many days? Any bleeding or spotting between periods? Any bleeding or spotting after intercourse?	es I No YES NO
Do you have pain during or after intercourse? Do you have frequent headaches? If yes to any of the above: Describe location, character, radiation or distribution, frequency and duration of any of the above answers:	How many pads do you use on heaviest days? Do you use Pads or Tampax Scented? Yee Any clots? How large? Do you have to stay in bed on heavy days? Do you miss work or school regularly each month? If yes, how many days? Any bleeding or sporting between periods? Any bleeding or sporting after intercourse? N: Do you have any significant pain with periods? Do you take any medication to relieve it regularly?	es DNo YES NO ———————————————————————————————————
Do you have frequent headaches?	How many pads do you use on heaviest days? Do you use Pads or Tampax Scented? Yee Any clots? How large? Do you have to stay in bed on heavy days? Do you miss work or school regularly each month? If yes, how many days? Any bleeding or spotting between periods? Any bleeding or spotting after intercourse? N: Do you have any significant pain with periods? Do you take any medication to relieve it regularly? Do you have any lower abdominal pain at other times of the monthy	es I No YES NO ———————————————————————————————————
If yes to any of the above: Describe location, character, radiation or distribution, frequency and duration of any of the above answers:	How many pads do you use on heaviest days? Do you use Pads or Tampax Scented? Yee Any clots? How large? Do you have to stay in bed on heavy days? Do you miss work or school regularly each month? If yes, how many days? Any bleeding or spotting between periods? Any bleeding or spotting after intercourse? N: Do you have any significant pain with periods? Do you take any medication to relieve it regularly? Do you have any lower abdominal pain at other times of the mont Do you have pain during or after intercourse?	es I No YES NO ———————————————————————————————————
the above answers:	How many pads do you use on heaviest days? Do you use Pads or Tampax Scented? Yee Any clots? How large? Do you have to stay in bed on heavy days? Do you miss work or school regularly each month? If yes, how many days? Any bleeding or sporting between periods? Any bleeding or sporting after intercourse? N: Do you have any significant pain with periods? Do you take any medication to relieve it regularly? Do you have any lower abdominal pain at other times of the mont Do you have pain during or after intercourse? Do you have frequent headaches?	es INo YES NO Th?
	How many pads do you use on heaviest days? Do you use Pads or Tampax Scented? Yee Any clots? How large? Do you have to stay in bed on heavy days? Do you miss work or school regularly each month? If yes, how many days? Any bleeding or spotting between periods? Any bleeding or spotting after intercourse? Oo you have any significant pain with periods? Do you take any medication to relieve it regularly? Do you have any lower abdominal pain at other times of the mont Do you have pain during or after intercourse? Do you have frequent headaches? If yes to any of the above: Describe location, character, radiation of	es INo YES NO Th?
	How many pads do you use on heaviest days? Do you use Pads or Tampax Scented? Yee Any clots? How large? Do you have to stay in bed on heavy days? Do you miss work or school regularly each month? If yes, how many days? Any bleeding or spotting between periods? Any bleeding or spotting after intercourse? Oo you have any significant pain with periods? Do you take any medication to relieve it regularly? Do you have any lower abdominal pain at other times of the mont Do you have pain during or after intercourse? Do you have frequent headaches? If yes to any of the above: Describe location, character, radiation of	es INo YES NO Th?
	How many pads do you use on heaviest days? Do you use Pads or Tampax Scented? Yee Any clots? How large? Do you have to stay in bed on heavy days? Do you miss work or school regularly each month? If yes, how many days? Any bleeding or spotting between periods? Any bleeding or spotting after intercourse? N: Do you have any significant pain with periods? Do you take any medication to relieve it regularly? Do you have any lower abdominal pain at other times of the mont Do you have pain during or after intercourse? Do you have frequent headaches? If yes to any of the above: Describe location, character, radiation of	es INo YES NO Th?
	How many pads do you use on heaviest days? Do you use Pads or Tampax Scented? Yee Any clots? How large? Do you have to stay in bed on heavy days? Do you miss work or school regularly each month? If yes, how many days? Any bleeding or spotting between periods? Any bleeding or spotting after intercourse? Do you have any significant pain with periods? Do you take any medication to relieve it regularly? Do you have any lower abdominal pain at other times of the mont Do you have pain during or after intercourse? Do you have frequent headaches? If yes to any of the above: Describe location, character, radiation of the above answers:	es □ No YES NO th? cor distribution, frequency and duration of any of

Discharge: Do you have any chronic or pesistent discharge? What color is in? Does it have a had odo? Have you had inching? Do you wear a pad for it? Do you occube? Have you been accated for vaginitis before? Have you been accated for vaginitis before? How often? Do you have or have you had accently: Burning on urination Blood in urine Undue frequency Usgency about urinating. Do you get up a traight or urinate? How many times? Do you wet youself involuntatily with any of the following: coupling sneezing, laughing, running, lifting or going up or down staits? Do you have a week stream? Wene you a bed wetter as a child? Have you had any bladder or kidney infections? Have you ere steen a urologie? Any change in bowel habit? Do you have get was teen a urologie? Any change in bowel habit? Do you have pad bladder or kidney infections? Have you were steen a urologie? Any change in bowel habit? Do you have frequent or chronic disturba? Any shown ulce? Any shown ulce? Any shown ulce? Any shown gill bladder distast? Any shown we gill enter shown and distast. Bratt risasses or humps Bratt discharge. Pablistions. Bratt discharge. Problem with sexual function. Blatt Octotro Pills.	Three	тырск.			
What color is it? Does it have a bad odot? Have you had inching? Do you wear a pad for it? How often? Have you been rested for vaginitis before? Have you been rested for vaginitis before? How many times? Do you know what type? Trichomonous Monilia Non-Specific When were you last treated? When were you last treated? When were you last treated? When were you had recently: Burning on urination Blood in wine. Undue frequency. Usgency about urinating. Do you get up at night to urinate? How many times? Do you get up at night to urinate? How many times? Were you a bed wetter as a child? Have you had any bladder or kidney infections? Have you and any bladder or kidney infections? Have you ever had kidney x-rays? Have you ever had kidney x-rays? Have you ever had kidney x-rays? Have you ever seen a urologis? G.I. G.I. Are you chronically constipated? Any change in howel habit? Do you have seen a urologis? Do you have sup blood in stools? Nany known ubear? Any known ubear? Number of cigarentes per day Do you drink resplating? How much per day? Do you only clare karstwear? How much per day? Number of cigarentes per day Do you drink resplating? How much per day? Shortness of breath. Discincess Breast masses or homps Breast days Defended t	Disc		: discharge)	. <u>YES</u>	<u>N</u> (
Does is have a bad odor? Have you had inching? Do you wear a pad for it? Do you couche? How often? How often? How often? How many times? Do you know what type? Trichomonons Monilia Non-Specific When were you last tested? What teatment did you receive? G.U. Do you have or have you had recently: Burning on urintion Blood in urine. Undue frequency. Usgency about uninating. Do you get up at night to urinate? How many times? Do you wet yourself involuntarily with any of the following: coughing, sneezing, laughing, rouning, lifting or going up or down smits? Do you have as weak stream? Were you a bed wetter as a child? Have you had any bladder on kidney infections? How many times? Have you even the kidney scrays? Have you even the kidney scrays? Have you even had bidney scrays? How any times? Do you thronically constipated? Any change in bowel habit? Do you have frequent or choonic diarrhen? Any known aller? Any known aller? Any known aller? Nown any blood in stools? Do you have frequent or choonic diarrhen? Any known aller? Nown any fines? Nown and hadder disease? Any known aller? Any known aller? Nown and hadder disease? Any known and hadder sicase? Any contain regularity? How much per day? Do you on or or or have you ever used coke, heroin, or marijuana? OTHER: Have you had any of the following? Shortness of breath. Disalness. Breat misses or humps Breat file Control Halls Breat Control Halls Breat Contr		What color is it?	constraiger		
Have you had inching? Do you wear a pad for it? Do you wear a pad for it? Do you douche? How often? What do you use? Have you been created for vaginitis before? How many times? Do you know what type? Trichomonous Monilis Non-Specific When were you last treated? What teatment did you receive? G.U. Do you have or have you had eccently: Burning on urination Blood in usine Undue frequency Urgency about urinating Do you get up at night to urinate? How many times? Do you have early investigation of the following: coughing, sneezing, laughing, nunning, lifting or going up or down stairs? Do you have a weak stream? Were you a bed wetter as a child? Have you had any bladder or kidney infections? How many times? When was the last one? Have you ever that kidney x-rays? Have you ever sen a unologis? G.I. Are you chronically constipated? Any change in bowel habit? Do you knee a weak pladed or kidney infections? How often? Do you have any blood in stools? Do you have frequent or chronic diarrhes? Any known gall bladder disease? Any known gall bladder theses? Any known gall bladder asses? Any known gall bladder or sent of the sent of circums are sent of comments are sent of circums ar					
Do you douche? How often? How often? How often? How often? How often? What do you use? How many times? Do you know what type? Trichomonous Monilia Non-Specific When wrete you last treated? What teatment did you receive? G.U. Do you have or have you had eccently: Burning on urination Blood in usine. Undue frequency. Utgency shoot urinating. Do you get up at night to urinate? How many times? Do you wet yourself involuntarily with any of the following: coughing, sneezing, laughing, noning, lifting or going up or down suits? Do you have a weak stream? Wese you a bed wetter as a child? Have you had any bladder or kidney infections? Have you bed were the kidney x-rays? Have you creat had kidney x-rays? Have you creat had kidney x-rays? Have you creat had kidney x-rays? Have you have any blood in stools? Do you have frequent or chonic diarthen? Any known gall bladder disease? Any known use? Any known loca? Any known intertitual or stomach disorder? HABITS Do you smoke? Number of cigarettes per day Do you drink regularly? How much per day? Do you now or have you ever used coke, heroin, or matijuana? OTHER: Have you had any of the following? Shortness of breath Dizations. Breast misses or hamps. Breast discharge. Problem with sexual function. BRAND NAME DATES OF USAGE REASON FOR DISCONTINUATION BIRTH CONTROL. METHOD BRAND NAME DATES OF USAGE REASON FOR DISCONTINUATION BIRTH CONTROL.		Have you had itching?,,			
Do you douche? How often? What do you use? Have you becan treated for vaginitis before? How many times? Do you know what type? Trichomonons Monilia Non-Specific When were you har treated? G.U. Do you have or have you had secently: Burning on utination Blood in urine. Undue frequency. Urgency about utinating. Do you get up at night ro utinate? How many times? Do you wet yourself involuntarily with any of the following: coughing, sneezing, laughing, suoning, lifting or going up or down stairs? Do you thave a weak steam? Were you a bed wetter as a child? Have you have any bladder or kidney infections? How many times? When was the last one? Have you ever seen a utologist? Any expange in bowel habir? Do you take lastative? How often? Do you have a weak placed on kidney infections? How often? Do you have a placed in stools? Any known ulce? Any known often you were seen to chronic diasthes? Any known ulce? Any known often you were seen to chronic diasthes? Any known ulce? Any known gold bladder disease? Any other known intestinal or stomach disorder? HABITS Do you have any blood in stools? HABITS On you on wor have you ever used coke, heroin, or matijuana? OTHER: Have you now or have you ever used coke, heroin, or matijuana? OTHER: Have you now or have you ever used coke, heroin, or matijuana? OTHER: Have you now or have you ever used coke, heroin, or matijuana? OTHER: Have you now or have you ever used coke, heroin, or matijuana? OTHER: Have you now or have you ever used coke, heroin, or matijuana? OTHER: Have you had any of the following? Shortmess of breath. Dizziness. Breast masses or lumps Breast dischage. Problem with sexual function. BRAND NAME DATES OF USAGE REASON FOR DISCONTINUATION BIRTH CONYROL. METHOD BRAND NAME DATES OF USAGE		Do you wear a pad for it?			
How often? Have you been treated for vaginitis before? How many times? Do you know what type? Trichomonons Monilia Non-Specific When wete you last treated? What teatment did you receive? G.U. To you have or have you had recently: Burning on utination Blood in urine. Undue frequency Ungency about utinating. Do you get up at night to utinate? How many times? Do you wet yourself involuntarily with any of the following: coughing, sneezing, laughing, naming, lifting or going up or down stairs? Do you wet yourself involuntarily with any of the following: coughing, sneezing, laughing, naming, lifting or going up or down stairs? How many times? Were you a bod wetter as a child? Have you had any bladder or kidney infections? How many times? When was the last one? Have you ever had kidney x-tays? Have you ever seen a utologist? G.I. G.I. Are you chronically constipated? Any change in bowel habit? Do you take lastives? How often? Do you have any blood in stools? Do you have any blood in stools? Do you have any blood in stools? Any known gall bladder disease? Any known often? Any known often? Any known of cigactetes per day Do you drink regulativ? How much per day? Do you drink regulativ? Do you on drink regulativ? How much per day? Do you on where her be on the proper of the following? Shortness of breath. Dizziness. Palpitations. Breatt masses or lumps Breatt dischange. Problem with sexual function. BERTHO ONTROY. METHOD BRAND NAME DATES OF USAGE REASON FOR DISCONTINUATION BIRTHO ONTROY.		Do you douche?	***************************************	411	
How many times? Do you know what type? Trichomonoas Monilia Non-Specific When were you last treated? What treatment did you receive? G.U. Do you have or have you had recently: Burning on utination. Blood in urine. Undue frequency Urgency about utinating. Do you get up at night to utinate? How many times? Do you wet yourself involuntatily with any of the following: coughing, sneezing, laughing, sunning, lifting or going up or down stairs? Do you have a weak stream? When you a bod werter as a child? Have you had any bladder or kidney infections? How many times? When was the last one? Have you ever had kidney x-rays? Have you ever the kidney x-rays? Any change in bowed labils? Do you have seen a urologist? Any change in bowed labils? Do you have any blood in stools? Do you have any blood in stools? Any known gall bladder disease? Any known user? Any known user? Any known often? Number of cigacretes per day Do you drink regolatily? How much per day? Do you drank regolatily? How much per day? Do you now here howen intestinal or stomach disorder? Have you had any of the following? Shortness of breath. Dizziness. Palpitations. Breast misses or lumps.		How often?	What do you use?		
Do you know what type? Trichomonoas Monilia Nan-Specific When were you last treated? What treatment did you receive? G.U. Do you have or have you had recently: Burning on urination Blood in urine Undue frequency Urgency about urinating Do you get up at right to urinate? How many times? Do you wet yourself involuntarily with any of the following: coughing, sneezing, laughing, running, lifting or going up or down stairs? Do you have a weak cream? Were you a bed were as a child? Have you had any bladder or kidney infections? Have you and any bladder or kidney infections? Have you ever had kidney x-rays? Have you ever had kidney x-rays? Have you ever seen a untologist? G.I. Att you chronically constipated? Any change in bowel habid? Do you take laxatives? How often? Do you have frequent or chronic diarthea? Any known gall bladder disease? Any known ulces? Any known gall bladder disease? Any known gall bladder disease? Any known ulces? Number of cigarettes per day Do you drink regularly? How much per day? Do you drank regularly? How much per day? Breast discharge. Palpitations. Breast masses or lumps. Breast discharge. Problem with sexual function. BIRTH CONTROL: METHOD BRAND NAME DATES OF USAGE REASON FOR DISCONTINUATION Eith Control Pills TIDD		Have you been treated for vaginitis be	fore?		
When were you last treated? What treatment did you receive? G.U. Do you have or have you had secently: Burning on urination Blood in urine Undue frequency Urgency about urinating Do you get up at night to urinate? How many times? Do you wet yourself involuntarily with any of the following: couphing, succaing, laughing, running, lifting or going up or down stairs? Do you have a weak cream? Were you a bed wetter as a child? Have you about utinating Were you a bed wetter as a child? Have you a very had didney x-tays? Have you ever had kidney x-tays? Have you ever seen a utologist? G.I. Are you chronically constipated? Any change in bowel habit? Do you take laxafuse? How often? Do you have frequent or chronic distarbea? Any known ulcer? Any thorwn gib bladder disease? Any other known intestinal or stomach disorder? HABITS Do you smoke? Number of cigarettes per day Do you drink regularly? How much per day? Do you on or have you ever used coke, heroin, or matijuana? OTHER: Have you had any of the following? Shortmess of breath. Dizziness Palpitations. Breat masses or lumps Breat discharge. Problem with sexual function. BERTH CONTROL: METHOD BEAND NAME DATES OF USAGE REASON FOR DISCONTINUATION Eith Control Pills			37 77 37 77	_	
G.U. Do you have or have you had recently: Burting on urination Blood in urine. Undue frequency. Urgency about urinating. Do you get up at night to urinate? How many times? Do you wet yourself involuntarily with any of the following: coughing, sneezing, laughing, running, lifting or going up or down stairs? Do you have a weak stream? Were you a bed wetter as a child? Have you had any bladder or kidney infections? How many times? When was the last one? Have you ever seen a urologist? G.I. Are you chronically constipated? Any change in bowel habid? Do you take laxatives? How often? Do you have any blood in stools? Do you have frequent or chronic diarthea? Any known ukee? Any known ukee? Any known intestinal or stomach disorder? HABITS Do you smoke? Number of digarettes per day Do you drink regularly? How much per day? Do you now or have you ever used coke, heroin, or matijuana? OTHER: Have you had any of the following? Shortness of breath. Dizziness. Palpirations. Breat misses or lumps Breat discharge. Problem with sexual function. BIRTH CONTROL: METHOD BRAND NAME DATES OF USAGE REASON FOR DISCONTINUATION Eight Control Pills		When were you last treated?	noas Monilia Non-Speci	nc	
G.U. Do you have or have you had recently: Burting on urination Blood in urine. Undue frequency. Urgency about urinating. Do you get up at night to urinate? How many times? Do you wet yourself involuntarily with any of the following: coughing, sneezing, laughing, running, lifting or going up or down stairs? Do you have a weak stream? Were you a bed wetter as a child? Have you had any bladder or kidney infections? How many times? When was the last one? Have you ever seen a urologist? G.I. Are you chronically constipated? Any change in bowel habid? Do you take laxatives? How often? Do you have any blood in stools? Do you have frequent or chronic diarthea? Any known ukee? Any known ukee? Any known intestinal or stomach disorder? HABITS Do you smoke? Number of digarettes per day Do you drink regularly? How much per day? Do you now or have you ever used coke, heroin, or matijuana? OTHER: Have you had any of the following? Shortness of breath. Dizziness. Palpirations. Breat misses or lumps Breat discharge. Problem with sexual function. BIRTH CONTROL: METHOD BRAND NAME DATES OF USAGE REASON FOR DISCONTINUATION Eight Control Pills		What treatment did you receive?			
Do you have or have you had recently: Burning on urination Blood in urine. Undue frequency Urgency about urinating. Do you get up at night to urinate? How many times? Do you wet yourself involuntarily with any of the following: coughing, sneezing, laughing, running, lifting or going up or down steirs? Do you have a weak steam? Were you a bed wetter as a child? Have you had any bladder or kidney infections? How many times? When was the last one? Have you ever had kidney x-rays? Have you ever had kidney x-rays? Have you ever seen a urologist? G.I. Are you chronically constipated? Any change in bowel habli? Do you have any blood in stools? Do you have feequent or chronic diarthea? Any known tinces? Any known gall bladder disease? Any known gall bladder disease? Any known intestinal or stomach disorder? HABITS Do you smoke? Number of cigarettes per day Do you drink regulatly? How much per day? Do you now or have you ever used coke, heroin, or matijuana? OTHER: Have you had any of the following? Shormess of breath Dizziness Palpitations. Breat masses or lumps Breat discharge. Problem with sexual function. BIRTH CONTROL: METHOD BRAND NAME DATES OF USAGE REASON FOR DISCONTINUATION Birth Control Pills IUD	G YY		<u> </u>		
Burding on urination Blood in urine Blood in urine Undue frequency Urgency about urinating Do you get up at night to urinate? How many times? Do you wet yourself involuntarily with any of the following: coughing, sneezing, laughing, running, lifting or going up or down stairs? Do you have a weak stream? Were you a bed wretter as a child? Have you had any bladder or kidney infections? How many times? When was the last one? Have you ever seen a urologist? G.I. Are you chronically constipated? Any change in bowel habit? Do you have laxatives? How often? Do you have any blood in stools? Do you have any blood in stools? Any known ulcer? Any known ulcer? Any known intestinal or stomach disorder? HABITS Do you smoke? Number of cigatentes per day Do you drink regularly? How much per day? Do you drink regularly? How much per day? Do you now or have you ever used coke, heroin, or matijuana? OTHER: Have you had any of the following? Shortness of breath Dizziness Palpitations. Breat masses or lumps Breat discharge. Problem with sexual function. BIRTH CONTROL: METHOD BRAND NAME DATES OF USAGE REASON FOR DISCONTINUATION Birth Control Pills IUD	0.0.	"Do you have or have you had recently:	•		
Blood in urine. Undue frequency Urgency about utinating. Do you get up at night to utinate? How many times? Do you wet yourself involuntarily with any of the following: coughing, sneezing, laughing, running, lifting or going up or down stairs? Were you a bed wetter as a child? Have you had we bladder or kidney infections? How many times? When was the last one? Have you ever had kidney x-rays? Have you ever seen a urologist? G.I. Are you chronically constipated? Any change in bowel habit? Do you take laxatives? How often? Do you have frequent or chronic diarches? Any known ulcer? Any known ulcer? Any known gall bladder disease? Any known gall bladder disease? Any known intestinal or stomach disorder? HABITS Do you smoke? Number of cigatertes per day Do you drink regularly? How much per day? Do you now or have you ever used coke, heroin, or matijuana? OTHER: Have you had any of the following? Shortness of breath Dizziness Palpitations. Breat messes or lumps Breat discharge. Problem with sexual function. BIRTH CONTROL: METHOD BRAND NAME DATES OF USAGE REASON FOR DISCONTINUATION Birth Control Pills IUD					
Unduc frequency Urgency about utinating Do you get up at night to utinate? How many times? Do you wer yourself involuntarily with any of the following: coughing, sneezing, laughing, running, lifting or going up or down stairs? Do you have a weak stream? Wexe you a bed wetter as a child? Have you had any bladder or kidney infections? How many times? When was the last one? Have you ever had kidney x-rays? Have you ever had kidney x-rays? Have you ever seen a urologist? G.I. Are you chronically constipated? Any change in bowel habit? Do you take laxetives? How often? Do you have frequent or chronic diarthea? Any known gall bladder disease? Any known gall bladder disease? Any known gall bladder disease? Any other known intestinal or stomach disorder? HABITS Do you smoke? Number of cigarettes per day Do you drike regularly? How much per day? Do you now or have you ever used coke, heroin, or matijuana? OTHER: Have you had any of the following? Shortness of breath Dizziness Palpirations. Breast masses or lumps Breast discharge. Problem with sexual function. BIRTH CONTROL: METHOD BRAND NAME DATES OF USAGE REASON FOR DISCONTINUATION Birth Control Pills		Blood in urine			
Urgency about utinating. Do you get up at night to utinate? How many times? Do you wet yourself involuntarily with any of the following: coughing, sneezing, laughing, running, lifting or going up or down stairs? Do you have a weak stream? West you a bed wetter as a child? Have you had poladder or kidney infections? How many times? When was the last one? Have you ever had kidney x-rays? Have you ever seen a urologist? G.I. Are you chronically constipated? Any change in bowel habit? Do you hate laxatives? How often? Do you have any blood in stools? Do you have frequent or chronic diarrhea? Any known ulcer? Any known ulcer? Any known intestinal or stomach disorder? HABITS Do you smoke? Number of cigarettes per day Do you drink regularly? How much per day? Do you drink regularly? How much per day? Do you now or have you ever used coke, heroin, or marijuana? OTHER: Have you had any of the following? Shortness of breath. Dizziness Palpirations. Breast masses or lumps. Breast discharge. Problem with sexual function. BERTH CONTROL: METHOD BRAND NAME DATES OF USAGE REASON FOR DISCONTINUATION Birth Control Pills IUD		Undue frequency			
Do you get up at night to urinate? How many times? Do you wet yourself involuntarily with any of the following: coughing, sneezing, laughing, running, lifting or going up or down stairs? Do you have a weak stream? Were you a bed wetter as a child? Have you bed wetter as a child? Have you cver had kidney infections? Have you cver had kidney x-rays? Have you over seen a urologist? G.I. Are you chronically constipated? Any change in bowel habit? Do you take laxatives? How often? Do you have any blood in stools? Do you have frequent or chronic diarrhea? Any known ulcer? Any known ulcer? Any known intestinal or stomach disorder? HABITS Do you smoke? Number of cigarettes per day Do you drike regularly? How much per day? Do you drike regularly? How much per day? Do you now or have you ever used coke, heroin, or matijuana? OTHER: Have you had any of the following? Shortness of breath. Dizziness Palpirations. Breast misses or lumps Breast discharge. Problem with sexual function. BIRTH CONTROL: METHOD BRAND NAME DATES OF USAGE REASON FOR DISCONTINUATION Birth Control Pills IUD		Urgency about urinating	4.4.4.4	All	
Do you wet youtself involuntarily with any of the following: coughing, steezing, laughing, running, lifting or going up or down staits? Do you have a weak stream? Were you a bed wetter as a child? Have you had any bladder or kidney infections? How many times? When was the last one? Have you ever had kidney x-rays? Have you ever seen a urologist? G.I. Are you chronically constipated? Any change in bowel habit? Do you take laxatives? How often? Do you have any blood in stools? Do you have any blood in stools? Any known ulcer? Any known gall bladder disease? Any known gall bladder disease? Any shown gall bladder disease? Any other known intestinal or stomach disorder? HABITS Do you smoke? Number of cigarettes per day Do you drink regularly? How much per day? Do you now or have you ever used coke, heroin, or matijuana? OTHER: Have you had any of the following? Shortness of becath Dizziness Palpirations. Breast masses or humps Breast discharge. Problem with sexual function. BIRTH CONTROL: METHOD Brith Control Pills IUD		Do you get up at night to urinate?	***************************************		
coughing, sueezing, laughing, running, lifting or going up or down staits? Do you have a weak stream? West you a bed wetter as a child? Have you had any bladder or kidney infections? How many times? When was the last one? Have you ever had kidney x-rays? Have you ever seen a urologist? G.I. Are you chronically constipated? Any change in bowel habit? Do you take laxatives? How often? Do you sake laxatives? Any known pall bladder of chronic diarrhea? Any known gall bladder disease? Any known gall bladder disease? Any known intestinal or stomach disorder? HABITS Do you smoke? Number of cigarettes per day Do you drink regularly? How much per day? Do you drink regularly? How much per day? Do you now or have you ever used coke, heroin, or marijuana? OTHER: Have you had any of the following? Shortness of breath Dizziness Palpitations. Breast masses or lumps Breast masses or lumps Breast masses or lumps Breast misses or lumps					
Do you have a weak stream? Were you a bed wetter as a child? Have you had any bladder or kidney infections? How many times? When was the last one? Have you ever had kidney x-rays? Have you ever seen a unologist? G.I. Are you chronically constipated? Any change in bowel habit? Do you take laxatives? How often? Do you have any blood in stools? Do you have frequent or chronic diarrhea? Any known ulcer? Any known gall bladder disease? Any known gall bladder disease? Any known gall bladder disease? Number of cigarettes per day Do you drink regularly? HABITS Do you drink regularly? How much per day? Do you now or have you ever used coke, heroin, or marijuana? OTHER: Have you had any of the following? Shortness of breath. Dizziness Palpitations. Breast masses or lumps Breast discharge. Problem with sexual function. BIRTH CONTROL: METHOD BRAND NAME DATES OF USAGE REASON FOR DISCONTINUATION Bith Control Pills IUD		Do you wet yourself involuntarily with	any of the following:		
Were you a bed wetter as a child? Have you had any bladder or kidney infections? How many times? When was the last one? Have you ever had kidney x-rays? Have you ever seen a urologist? G.I. Are you chronically constipated? Any change in bowel habit? Do you take laxatives? How often? Do you have any blood in stools? Do you have any blood in stools? Any known ulcer? Any known ulcer? Any known ulcer? Any known intestinal or stomach disorder? HABITS Do you smoke? Number of cigarettes per day Do you drink regularly? How much per day? Do you now or have you ever used coke, heroin, or marijuana? OTHER: Have you had any of the following? Shortness of breath Dizziness Palpirations Breast masses or lumps Breast discharge Problem with sexual function Birth CONTROL: METHOD BRAND NAME DATES OF USAGE REASON FOR DISCONTINUATION Birth Control Pills IUD		Coughing, sneezing, laughing, running, l	utting or going up or down str	eirs?	
Have you had any bladder or kidney infections? How many times? When was the last one? Have you ever had kidney x-rays? Have you ever seen a urologist? G.I. Are you chronically constipated? Any change in bowel habit? Do you take laxatives? How often? Do you have any blood in stools? Do you have frequent or chronic diarthea? Any known ulcer? Any known gall bladder disease? Any other known intestinal or stomach disorder? HABITS Do you smoke? Number of cigarettes per day Do you drink regularly? How much per day? Do you row or have you ever used coke, heroin, or marijuana? OTHER: Have you had any of the following? Shortness of breath Dizziness Palpitations Breast masses or lumps Breast discharge. Problem with sexual function. BIRTH CONTROL: METHOD BRAND NAME DATES OF USAGE REASON FOR DISCONTINUATION BIRTH CONTROL: METHOD BRAND NAME DATES OF USAGE REASON FOR DISCONTINUATION BIRTH CONTROL:		Were you a bed wetter as a child?			
How many times? When was the last one? Have you ever had kidney x-rays? Have you ever seen a urologist? G.I. Are you chronically constipated? Any change in bowel habit? Do you take laxatives? How often? Do you have any blood in stools? Do you have frequent or chronic diarthea? Any known ulcer? Any known gall bladder disease? Any known gall bladder disease? Any other known intestinal or stomach disorder? HABITS Do you smoke? Number of cigarettes per day Do you drink regularly? How much per day? Do you now or have you ever used coke, heroin, or marijuana? OTHER: Have you had any of the following? Shortness of breath Dizziness Palpitations Breast masses or lumps Breast discharge. Problem with sexual function. BIRTH CONTROL: METHOD BRAND NAME DATES OF USAGE REASON FOR DISCONTINUATION BIRTH CONTROL: METHOD BRAND NAME DATES OF USAGE REASON FOR DISCONTINUATION BIRTH CONTROL:		Have you had any bladder or kidney inf	fections?		
Have you ever had kidney x-rays?		How many times? W	hen was the last one?		
Have you ever seen a urologist? G.I. Are you chronically constipated? Any change in bowel habit? Do you take laxatives? How often? Do you have any blood in stools? Do you have frequent or chronic diarthea? Any known ulcer? Any known gall bladder disease? Any known gall bladder disease? Any other known intestinal or stomach disorder? HABITS Do you smoke? Number of cigatettes per day Do you drink regularly? How much per day? Do you now or have you ever used coke, heroin, or marijuana? OTHER: Have you had any of the following? Shortness of breath. Dizziness. Palpitations. Breast masses or lumps Breast discharge. Problem with sexual function. BIRTH CONTROL: METHOD BRAND NAME DATES OF USAGE REASON FOR DISCONTINUATION Birth Control Pills IUD		Have you ever had kidney x-rays?		***************************************	
Are you chronically constipated? Any change in bowel habit? Do you take laxatives? How often? Do you have any blood in stools? Do you have frequent or chronic diarthea? Any known ulcer? Any known gall bladder disease? Any known gall bladder disease? Any other known intestinal or stomach disorder? HABITS Do you smoke? Number of cigarettes per day Do you drink regularly? How much per day? Do you now or have you ever used coke, heroin, or matijuana? OTHER: Have you had any of the following? Shortness of breath Dizziness Palpitations. Breast masses or lumps Breast discharge Problem with sexual function. BIRTH CONTROL: METHOD BRAND NAME DATES OF USAGE REASON FOR DISCONTINUATION Birth Control Pills IUD		Have you ever seen a utologist?			
Any change in bowel habit? Do you take laxatives? How often? Do you have any blood in stools? Do you have frequent or chronic diarthea? Any known ulcer? Any known gall bladder disease? Any other known intestinal or stomach disorder? HABITS Do you smoke? Number of cigarettes per day Do you drink regularly? How much per day? Do you drink regularly? How much per day? Do you now or have you ever used coke, heroin, or marijuana? OTHER: Have you had any of the following? Shortness of breath Dizziness Palpirations Breast masses or lumps Breast discharge. Problem with sexual function Birth CONTROL: METHOD BRAND NAME DATES OF USAGE REASON FOR DISCONTINUATION Birth Control Pills IUD	G.I.				
Any change in bowel habit? Do you take laxatives? How often? Do you have any blood in stools? Do you have frequent or chronic diarrhea? Any known ulcer? Any known gall bladder disease? Any other known intestinal or stomach disorder? HABITS Do you smoke? Number of cigarettes per day Do you drink regularly? How much per day? Do you drink regularly? How much per day? Do you now or have you ever used coke, heroin, or marijuana? OTHER: Have you had any of the following? Shortness of breath. Dizziness Palpitations. Breast masses or lumps Breast discharge. Problem with sexual function. BIRTH CONTROL: METHOD BRAND NAME DATES OF USAGE REASON FOR DISCONTINUATION Birth Control Pills IUD		Are you chronically constipated?		***************************************	
How often? Do you have any blood in stools? Do you have frequent or chronic diarthea? Any known ulcer? Any known gall bladder disease? Any other known intestinal or stomach disorder? HABITS Do you smoke? Number of cigarettes per day Do you drink regularly? How much per day? Do you now or have you ever used coke, heroin, or marijuana? OTHER: Have you had any of the following? Shortness of breath Dizziness Palpirations. Breast masses or lumps Breast discharge. Problem with sexual function. BIRTH CONTROL: METHOD BRAND NAME DATES OF USAGE REASON FOR DISCONTINUATION Birth Control Pills IUD		Any change in bowel habit?		***************************************	
Do you have any blood in stools? Do you have frequent or chronic diarrhea? Any known ulcer? Any known gall bladder disease? Any other known intestinal or stomach disorder? HABITS Do you smoke? Number of cigarettes per day Do you drink regularly? How much per day? Do you now or have you ever used coke, heroin, or marijuana? OTHER: Have you had any of the following? Shortness of breath. Dizziness Palpitations. Breast masses or lumps Breast discharge. Problem with sexual function. BIRTH CONTROL: METHOD BRAND NAME DATES OF USAGE REASON FOR DISCONTINUATION Birth Control Pills IUD		Do you take laxatives?			
Do you have frequent or chronic diarrhea? Any known ulcer? Any known gall bladder disease? Any other known intestinal or stomach disorder? HABITS Do you smoke? Number of cigarettes per day Do you drink regularly? How much per day? Do you now or have you ever used coke, heroin, or marijuana? OTHER: Have you had any of the following? Shortness of breath Dizziness Palpitations. Breast masses or humps Breast discharge. Problem with sexual function. BIRTH CONTROL: METHOD BRAND NAME DATES OF USAGE REASON FOR DISCONTINUATION Birth Control Pills TUD					
Any known ulcer? Any known gall bladder disease? Any other known intestinal or stomach disorder? HABITS Do you smoke? Number of cigarettes per day Do you drink regularly? How much per day? Do you now or have you ever used coke, heroin, or marijuana? OTHER: Have you had any of the following? Shortness of breath Dizziness Palpitations Breast masses or lumps Breast discharge Problem with sexual function BIRTH CONTROL: METHOD BRAND NAME DATES OF USAGE REASON FOR DISCONTINUATION Birth Control Pills IUD		Do you have frament at about disput	~~^		
Any known gall bladder disease? Any other known intestinal or stomach disorder? HABITS Do you smoke? Number of cigarettes per day Do you drink regularly? How much per day? Do you now or have you ever used coke, heroin, or matijuana? OTHER: Have you had any of the following? Shortness of breath Dizziness Palpitations. Breast masses or himps Breast discharge. Problem with sexual function. BIRTH CONTROL: METHOD BRAND NAME DATES OF USAGE REASON FOR DISCONTINUATION Birth Control Pills IUD	•	Any known ulcer?	car		-
Any other known intestinal or stomach disorder? HABITS Do you smoke? Number of cigarettes per day Do you drink regularly? How much per day? Do you now or have you ever used coke, heroin, or matijuana? OTHER: Have you had any of the following? Shortness of breath Dizziness Palpitations Breast masses or lumps Breast discharge Problem with sexual function. BIRTH CONTROL: METHOD BRAND NAME DATES OF USAGE REASON FOR DISCONTINUATION Birth Control Pills IUD		Any known gall bladder disease?			
HABITS Do you smoke? Number of cigarettes per day Do you drink regularly? How much per day? Do you now or have you ever used coke, heroin, or marijuana? OTHER: Have you had any of the following? Shortness of breath Dizziness Palpitations. Breast masses or lumps Breast discharge Problem with sexual function. BIRTH CONTROL: METHOD BRAND NAME DATES OF USAGE REASON FOR DISCONTINUATION Birth Control Pills IUD		Any other known intestinal or stomach	disorder?		
Do you smoke? Number of cigarettes per day Do you drink regularly? How much per day? Do you now or have you ever used coke, heroin, or marijuana? OTHER: Have you had any of the following? Shortness of breath Dizziness Palpitations. Breast masses or lumps Breast discharge. Problem with sexual function. BIRTH CONTROL: METHOD BRAND NAME DATES OF USAGE REASON FOR DISCONTINUATION Birth Control Pills TUD	HABI				-
Number of cigarettes per day Do you drink regularly? How much per day? Do you now or have you ever used coke, heroin, or marijuana? OTHER: Have you had any of the following? Shortness of breath Dizziness Palpitations Breast masses or lumps Breast discharge Problem with sexual function BIRTH CONTROL: METHOD BRAND NAME DATES OF USAGE REASON FOR DISCONTINUATION Birth Control Pills TUD					
Do you drink regularly? How much per day? Do you now or have you ever used coke, heroin, or marijuana? OTHER: Have you had any of the following? Shortness of breath Dizziness Palpitations. Breast masses or lumps Breast discharge. Problem with sexual function. BIRTH CONTROL: METHOD BRAND NAME DATES OF USAGE REASON FOR DISCONTINUATION Birth Control Pills IUD		Number of cigarettes per day			
How much per day? Do you now or have you ever used coke, heroin, or marijuana? OTHER: Have you had any of the following? Shortness of breath Dizziness Palpirations Breast masses or lumps Breast discharge Problem with sexual function BIRTH CONTROL: METHOD BRAND NAME DATES OF USAGE REASON FOR DISCONTINUATION Birth Control Pills IUD		Do you drink regularly?	***************************************	FF151FF1-4//	
OTHER: Have you had any of the following? Shortness of breath Dizziness Palpitations Breast masses or lumps Breast discharge Problem with sexual function BIRTH CONTROL: METHOD BRAND NAME DATES OF USAGE REASON FOR DISCONTINUATION Birth Control Pills IUD		How much pet day?			
Have you had any of the following? Shortness of breath Dizziness Palpitations Breast masses or lumps Breast discharge Problem with sexual function BIRTH CONTROL: METHOD BRAND NAME DATES OF USAGE REASON FOR DISCONTINUATION Birth Control Pills IUD			e, heroin, or marijuana?		
Shortness of breath Dizziness Palpitations Breast masses or lumps Breast discharge Problem with sexual function BIRTH CONTROL: METHOD BRAND NAME DATES OF USAGE REASON FOR DISCONTINUATION Birth Control Pills IUD	OTHE		,		
Dizziness Palpitations Breast masses or lumps Breast discharge Problem with sexual function BIRTH CONTROL: METHOD BRAND NAME DATES OF USAGE REASON FOR DISCONTINUATION Birth Control Pills IUD		Have you had any of the following?			
Palpitations. Breast masses or lumps Breast discharge Problem with sexual function. BIRTH CONTROL: METHOD BRAND NAME DATES OF USAGE REASON FOR DISCONTINUATION Birth Control Pills IUD		Shortness of breath	145 ************************************		
Breast masses or lumps Breast discharge Problem with sexual function BIRTH CONTROL: METHOD BRAND NAME DATES OF USAGE REASON FOR DISCONTINUATION Birth Control Pills TUD					
Breast discharge Problem with sexual function BIRTH CONTROL: METHOD BRAND NAME DATES OF USAGE REASON FOR DISCONTINUATION Birth Control Pills TUD		Breast masses or hypers	***************************************		
Problem with sexual function BIRTH CONTROL: METHOD BRAND NAME DATES OF USAGE REASON FOR DISCONTINUATION Birth Control Pills IUD		Breast discharge	/		
BIRTH CONTROL: METHOD BRAND NAME DATES OF USAGE REASON FOR DISCONTINUATION Birth Control Pills IUD		Problem with sexual function			·—···
METHOD BRAND NAME DATES OF USAGE REASON FOR DISCONTINUATION Birth Control Pills IUD					
Birth Control Pills IUD	BIRTH		W. A.		
IUD			DATES OF USAGE	REASON FOR DISCONTINU	ATION
				· · · · · · · · · · · · · · · · · · ·	
1 12/01/10/11		TID			

Radiation therapy Other Describe previous YES answers: SURGERY: List all surgical procedures you have had.	\mathbf{P}_{I}										
Rheumatic fever Rheumatic heart disease German measles Venereal disease Pacumonia High blood pressure Diabetes Tuberculosis Chronic kidney disease Anarmia Hepatitis (yellow jaundice) Phlebitis Nervous breakdown Severe depression Epileppy Migraine headaches Bleeding tendencies Psychiatric illness Thyroid disease Congenital heart disease Radiation therapy Other Describe previous YES answers: SURGERY: List all surgical procedures you have had. DATE AFPROX PROCEDURE HOSPITAL LOCATION SUR OBSTETRICAL: List below all prepaneries and results including opentuneous miscarriages, abortions, complicated to the complete compl				DRY (If yes	, indica				n beside	each sectio	n)
Rheumatic heart disease German measles Venereal disease Paeumonia High blood pressure Diabetes Tuberculosis Chronic kidney disease Anemia Hepatits (yellow jaundice) Phlebitis Nervous breakdown Sevete depression Epilepsy Migraine headaches Bleeding tendencies Psychiatric illness Thytoid disease Congenital heatt disease Radiation therapy Other Describe previous YES answers: SURGERY: List all surgical procedures you have had. DATE APPROX PROCEDURE HOSPITAL LOCATION SUR OBSTETRICAL: List below all pregnancies and results including spontaneous miscarriages, abortions, complicated to the complete of th		_				YE	es n	40			
German measles Venereal disease Pneumonia High blood pressure Diabetes Tuberculosis Chronic kidney disease Anemia Hepatitis (yellow jaundice) Phlebitis Nervous breakdown Severe depression Epilepsy Migraine headaches Elecding tendencies Psychiatric illness Thyroid disease Congenital heart disease Radiation therapy Other Describe previous YES answers: SURGERY: List all surgical procedures you have had. DATE APPROX PROCEDURE HOSPITAL LOCATION SUR OBSTETRICAL: List below all pregnancies and results including spontaneous miscarriages, abortions, complicated in the procedure of th											
Venereal disease Paeumonia High blood pressure Diabetes Tuberculosis Chronic kidney disease Anemia Hepatitis (yellow jaundice) Phlebitis Nervous bzeakdown Severe depression Epilepsy Migraine headaches Bleeding teadencies Psychiatric illness Thyroid disease Congenital heart disease Radiation therapy Other Describe previous YES answers: SURGERY: List all surgical procedures you have had. DATE APPROX PROCEDURE HOSPITAL LOCATION SUR OBSTETRICAL: List below all pregnancies and results including spontaneous miscarriages, abortions, complicated to the complete of the compl				lisease							
Paeumonia High blood paessure Diabetes Tuberculosis Chronic kidney disease Anemia Hepatitis (yellow jaundice) Phlebitis Nervous breakdown Sevete depression Epilepsy Migraine headaches Bleeding tendencies Psychiatric illness Thyroid disease Congenital heart disease Radiation therapy Other Describe previous YES answets: SURGERY: List all surgical procedures you have had. DATE APPROX PROCEDURE HOSPITAL LOCATION SUR DATE APPROX PROCEDURE HOSPITAL LOCATION SUR OBSTETRICAL: List below all pregnancies and results including spontaneous miscarriages, abortions, complicated to the complex of the complex o							_ ` _				
High blood pressure Diabetes Tuberculosis . Chronic kidney disease Anemia Hepatitis (yellow jaundice) Phlebitis Nervous breakdowa Severe depression Epilepsy Migraine headaches Bleeding tendencies Psychiatric illness Thyroid disease Congenital heart disease Radiation therapy Other Describe previous YES answers: SURGERY: List all surgical procedures you have had. DATE APPROX PROCEDURE HOSPITAL LOCATION SUR OBSTETRICAL: List below all pregnancies and results including spontaneous miscarriages, abortions, complicated in MONTHLYRAR SEX ATBUILD GREEN TARGET ARBUILD GREEN TOPE OF LARGE DELIVERY AND STHESIA COMMENTS/COMMICATION NO MONTHLYRAR SEX ATBUILD GREEN TARGET ARBUILD GREEN TOPE OF LARGE DELIVERY AND STHESIA COMMENTS/COMMICATION 2		Venerea	l disease						•		76°
Diabetes Tuberculosis Chronic kidney disease Anemia Hepatitis (yellow jaundice) Phlebitis Nervous breakdown Sevete depression Epilepsy Migraine headaches Bleeding tendencies Psychiatric illness Thyroid disease Congenital heart disease Radiation therapy Other Describe previous YES answers: SURGERY: List all surgical procedutes you have had. DATE APPROX PROCEDURE HOSPITAL LOCATION SUR OBSTETRICAL: List below all pregnancies and results including spontaneous miscarriages, abortions, complicated to the complete state of the		Pneumo	nia				·				
Tuberrulgsis Chronic kidney disease Anemia Hepatitis (yellow jaundice) Phlebitis Nervous breakdowa Severe depression Epilepsy Migraine headaches Bleeding tradeacies Psychiatric illness Thyroid disease Congenital heart disease Radiation therapy Other Describe previous YES answers: SURGERY: List all surgical procedures you have had. DATE APPROX PROCEDURE HOSPITAL LOCATION SUR OBSTETRICAL: List below all pregnancies and results including spontaneous miscarriages, abortions, complicant NO MONTH/YEAR SEX AT SHATH GEST LABOR DELIVERY ANESTHESIA COMMENTS/COMPHENTIC		High blo	od pressi	ır c							
Chronic kidney disease Anemia Hepatitis (yellow jaundice) Phlebitis Nervous breakdowa Severe depression Epilepsy Migraine headaches Bleeding tendencies Psychiatric illness Thyroid disease Congenital heart disease Radiation therapy Other Describe previous YES answers: SURGERY: List all surgical procedutes you have had. DATE APPROX PROCEDURE HOSPITAL LOCATION SUR OBSTETRICAL: List below all pregnancies and results including spontaneous miscarriages, abortions, complication NO MONTH/YEAR SEX AT SIRTH OSST HOURS IN TYPE OR DELIVERY ANESTHESIA COMMENTS/COMPLICATIO 1 2 3 4 4 5 5		Diabetes						_			
Anemia Hepatitis (yellow jaundice) Phlebitis Nervous breakdown Severe depression Epilepsy Migraine headaches Eleeding tendencies Psychiatric illness Thyroid disease Congenital heart disease Radiation therapy Other Describe previous YES answers: SURGERY: List all surgical procedures you have had. DATE APPROX PROCEDURE HOSPITAL LOCATION SUR DATE APPROX PROCEDURE HOSPITAL LOCATION SUR OBSTETRICAL: List below all pregnancies and results including spontaneous miscarriages, abortions, complication MONTHIVEAR SEX ATRIBITH ORST LABOR DELIVERY AND STHESSIA COMMENTS/COMPULCATION 1 2 3 4 5 6 6 6 6 6 6 6 7 7 7 7 7 7 7 7 7 7 7 7		Tubercu	losis								
Hepatitis (yellow jaundice) Phlebitis Nervous breakdown Severe depxession Epilepsy Migraine headaches Bleeding tendencies Psychiatric illness Thyroid disease Congenital heart disease Radiation therapy Other Describe previous YES answers: SURGERY: List all surgical procedutes you have had. DATE APPROX PROCEDURE HOSPITAL LOCATION SUR OBSTETRICAL: List below all pregnancies and results including spontaneous miscarriages, abortions, compilication NO MONTHYEAR SEX ATSIBITH OBST LABOR DELIVERY ANESTHESIA CONDENSINGLATIC 1 2 3 4 5 6 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		Chronic	kidney di	sease							
Phlebitis Nervous breakdown Severe depression Epilepsy Migraine headaches Bleeding tendencies Psychiatric illness Thyroid disease Congenital heart disease Radiation therapy Other Describe previous YES answers: SURGERY: List all surgical procedures you have had. DATE APPROX PROCEDURE HOSPITAL LOCATION SUR BATE APPROX PROCEDURE HOSPITAL LOCATION SUR OBSTETRICAL: List below all pregnancies and results including spontaneous miscarriages, abortions, complicant NO MONTH/YEAR SEX ATBRITH GEST LABOR DELIVERY ANESTHESIA COMMENTS/COMPLICATIO 1 COMMENTS/COMPLICATIO 2 COMMENTS/COMPLICATIO 3 COMMENTS/COMPLICATIO 1 COMMENTS/COMPLICATIO 2 COMMENTS/COMPLICATIO 3 COMMENTS/COMPLICATIO 3 COMMENTS/COMPLICATIO 4 COMMENTS/COMPLICATIO 5 COMPLICATION COMPLI		Anemia									
Phlebitis Nervous breakdown Severe depression Epilepsy Migraine headaches Bleeding tendencies Psychiatric illness Thyroid disease Congenital heart disease Radiation therapy Other Describe previous YES answers: SURGERY: List all surgical procedures you have had. DATE APPROX PROCEDURE HOSPITAL LOCATION SUR BATE APPROX PROCEDURE HOSPITAL LOCATION SUR OBSTETRICAL: List below all pregnancies and results including spontaneous miscarriages, abortions, complicant NO MONTH/YEAR SEX ATBRITH GEST LABOR DELIVERY ANESTHESIA COMMENTS/COMPLICATIO 1 COMMENTS/COMPLICATIO 2 COMMENTS/COMPLICATIO 3 COMMENTS/COMPLICATIO 1 COMMENTS/COMPLICATIO 2 COMMENTS/COMPLICATIO 3 COMMENTS/COMPLICATIO 3 COMMENTS/COMPLICATIO 4 COMMENTS/COMPLICATIO 5 COMPLICATION COMPLI		Hepatitis	(yellow j	aundice)							
Severe depression Epilepsy Migraine headaches Bleeding tendencies Psychiatric illness Thyroid disease Congenital heart disease Radiation therapy Other Describe previous YES answers: SURGERY: List all surgical procedures you have had. DATE APPROX PROCEDURE HOSPITAL LOCATION SUR DATE APPROX PROCEDURE HOSPITAL LOCATION SUR OBSTETRICAL: List below all pregnancies and results including spontaneous miscarriages, abortions, complicated to the complex of t				•					ALAC-0. U		<u> </u>
Epilepsy Migraine headaches Bleeding tendencies Psychiatric illness Thyroid disease Congenital heart disease Radiation therapy Other Describe previous YES answers: SURGERY: List all surgical procedures you have had. DATE APPROX PROCEDURE HOSPITAL LOCATION SUR DATE APPROX PROCEDURE HOSPITAL LOCATION SUR OBSTETRICAL: List below all pregnancies and results including spontaneous miscarriages, abortions, complication NO MONTH/YEAR SEX ATBURTH ORST LABOR DELIVERY ANESTHESIA COMMENTS/COMPLICATION 2		Nervous	breakdov	vα		V					
Epilepsy Migraine headaches Bleeding tendencies Psychiatric illness Thyroid disease Congenital heart disease Radiation therapy Other Describe previous YES answers: SURGERY: List all surgical procedures you have had. DATE APPROX PROCEDURE HOSPITAL LOCATION SUR DATE APPROX PROCEDURE HOSPITAL LOCATION SUR OBSTETRICAL: List below all pregnancies and results including spontaneous miscarriages, abortions, complication NO MONTH/YEAR SEX ATBURTH ORST LABOR DELIVERY ANESTHESIA COMMENTS/COMPLICATION 2											
Migraine headaches Bleeding tendencies Psychiatric illness Thyroid disease Congenital heart disease Radiation therapy Other Describe previous YES answers: SURGERY: List all surgical procedures you have had. DATE APPROX PROCEDURE HOSPITAL LOCATION SUR DATE APPROX PROCEDURE HOSPITAL LOCATION SUR OBSTETRICAL: List below all pregnancies and results including spontaneous miscarriages, abortions, complication of Monthly and Sex AT SIRTH OBST LABOR DELIVERY ANESTHESIA COMMENTS/COMPLICATION OBSTETRICAL: List below all pregnancies and results including spontaneous miscarriages, abortions, complication of Monthly and Sex AT SIRTH OBST LABOR DELIVERY ANESTHESIA COMMENTS/COMPLICATION 1			1			·	_				********
Bleeding tendencies Psychiatric illness Thytoid disease Congenital heart disease Radiation therapy Other Describe previous YES answers: SURGERY: List all surgical procedures you have had. DATE APPROX PROCEDURE HOSPITAL LOCATION SUR DATE APPROX PROCEDURE HOSPITAL LOCATION SUR OBSTETRICAL: List below all pregnancies and results including spontaneous miscarriages, abortions, complicated to the complex of th			headache	·s		~					
Psychiatric illness Thyroid disease Congenital heart disease Radiation therapy Other Describe previous YES answers: SURGERY: List all surgical procedures you have had. DATE APPROX PROCEDURE HOSPITAL LOCATION SUR DATE APPROX PROCEDURE HOSPITAL LOCATION SUR OBSTETRICAL: List below all pregnancies and results including spontaneous miscarriages, abortions, complicated to the complete state of						~~ <u>~~</u>		· •			
Thyroid disease Congenital heart disease Radiation therapy Other Describe previous YES answers: SURGERY: List all surgical procedures you have had. DATE APPROX PROCEDURE HOSPITAL LOCATION SUR DATE APPROX PROCEDURE HOSPITAL LOCATION SUR OBSTETRICAL: List below all pregnancies and results including spontaneous miscarriages, abortions, complicated to the complete service of the complete		_		.0			_				
Congenital heart disease Radiation therapy Other Describe previous YES answers: SURGERY: List all surgical procedures you have had. DATE APPROX PROCEDURE HOSPITAL LOCATION SUR OBSTETRICAL: List below all pregnancies and results including spontaneous miscarriages, abortions, complicated to the complete to the compl											
Radiation therapy Other Describe previous YES answers: SURGERY: List all surgical procedures you have had. DATE APPROX PROCEDURE HOSPITAL LOCATION SUR DATE APPROX PROCEDURE HOSPITAL LOCATION SUR OBSTETRICAL: List below all pregnancies and results including spontaneous miscarriages, abortions, complication of the procedure o		-		icanca		·		<u>. </u>			
Other Describe previous YES answers: SURGERY: List all surgical procedures you have had. DATE APPROX PROCEDURE HOSPITAL LOCATION SUR OBSTETRICAL: List below all pregnancies and results including spontaneous miscarriages, abortions, complicate no monthlyear SEX ATERITH GEST LABOR DELIVERY ANESTHESIA COMMENTS/COMPLICATION 1 2 3 4 4 5 6 6 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7				ISCASC		·					
Describe previous YES answers: SURGERY: List all surgical procedures you have had. DATE APPROX PROCEDURE HOSPITAL LOCATION SUR OBSTETRICAL: List below all pregnancies and results including spontaneous miscarriages, abortions, complication in type of LABOR DELIVERY ANESTHESIA COMMENTS/COMPLICATION 1 2			шскару							******	
SURGERY: List all surgical procedures you have had. DATE APPROX PROCEDURE HOSPITAL LOCATION SUR OBSTETRICAL: List below all pregnancies and results including spontaneous miscarriages, abortions, complicated to the complex of the		-	<u></u>	XZCC							
OBSTETRICAL: List below all pregnancies and results including spontaneous miscarriages, abortions, complicated no month/year sex at birth Gest Labor Delivery anesthesia Comments/complicated Labor Delivery and Comments/Complicated Labor Delivery Labor Delivery And Comments/Complicated Labor Delivery L		Describe	breatons	I ES auswe	ers:					•	
OBSTETRICAL: List below all pregnancies and results including spontaneous miscarriages, abortions, complicated no month/year sex at birth Gest Labor Delivery anesthesia Comments/complicated Labor Delivery and Comments/Complicated Labor Delivery Labor Delivery And Comments/Complicated Labor Delivery L		· -									
OBSTETRICAL: List below all pregnancies and results including spontaneous miscarriages, abortions, complicated no month/year sex at birth Gest Labor Delivery anesthesia Comments/complicated Labor Delivery and Comments/Complicated Labor Delivery Labor Delivery And Comments/Complicated Labor Delivery L		***									
OBSTETRICAL: List below all pregnancies and results including spontaneous miscarriages, abortions, complicated no month/year sex atbiath gest labor delivery anesthesia comments/complicated labor delivery and sex atbiath gest labor delivery and se											
OBSTETRICAL: List below all pregnancies and results including spontaneous miscarriages, abortions, complicated no month/year sex atbiath gest labor delivery anesthesia comments/complicated labor delivery and sex atbiath gest labor delivery and se									,		
OBSTETRICAL: List below all pregnancies and results including spontaneous miscarriages, abortions, complicated no month/year sex at birth Gest Labor Delivery anesthesia Comments/complicated Labor Delivery and Comments/Complicated Labor Delivery Labor Delivery And Comments/Complicated Labor Delivery L	OT 11	D () T () T ()			,						
OBSTETRICAL: List below all pregnancies and results including spontaneous miscarriages, abortions, complications of the complex of the comple	201		_	-	-						
NO MONTH/YEAR SEX AT BIRTH GEST LABOR DELIVERY ANESTHESIA COMMENTS/COMPLICATION 2 3 4 5		DATE A	PPROX	P	ROCED	URE:	H	OSPITAL	LO	CATION	SURGEO
NO MONTH/YEAR SEX AT BIRTH GEST LABOR DELIVERY ANESTHESIA COMMENTS/COMPLICATION 2 3 4 5							- · · · · · · · · · · · · · · · · · · 		<u> </u>		
NO MONTH/YEAR SEX AT BIRTH GEST LABOR DELIVERY ANESTHESIA COMMENTS/COMPLICATION 2 3 4 5		<u> </u>					-				
NO MONTH/YEAR SEX AT BIRTH GEST LABOR DELIVERY ANESTHESIA COMMENTS/COMPLICATION 2 3 4 5							· 				
NO MONTH/YEAR SEX AT BIRTH GEST LABOR DELIVERY ANESTHESIA COMMENTS/COMPLICATION 2 3 4 5						<u> </u>					
NO MONTH/YEAR SEX AT BIRTH GEST LABOR DELIVERY ANESTHESIA COMMENTS/COMPLICATION 2 3 4 5	~ ~										
NO MONTH/YEAR SEX AT BIRTH GEST LABOR DELIVERY ANESTHESIA COMMENTS/COMPLICATION 2 3 4 5	$\frac{1}{1000}$	STETRICAL	List belo	w all pregn	ancies a	and results i	ncluding sp	ontaneous mis	carriage	s, abortions	, complications
1 2 3 4 5	NO	MONTH/YEAR	SEX	AT BIRTH	GEST	LABOR	DELIVERY	ANESTHESIA		COMMENTS/	COMPLICATIONS
3 4 5	1	ĺ									
3 4 5	h										
5	2	 				_	~~~	 			
5	-		ļ								
	-			1]	_				
	3							<u> </u>			
101 1 1 1 1 1 1 1	3 4										
7	3 4 5										

ALLERGIES:				•		
Are you allergi	c to any dru	gs or medication?	ΟY	es 🗆 No		
List drug		Тур	pe of re	action		
	~~~~~	<u> </u>	<del></del>	,		
Do you have h	ay fever or :	esthma? . D	Yes I	□ No		<del></del>
If yes, what tre	atiments do	you take?		<u> </u>		
		•				<del></del>
MEDICATIONS:						
List all medicat	ions present	ly being taken, if an	ıy			
DRUG		REASON		HOW LONG TAKEN		ANY SIDE EFFECTS
	-	•				
					·	
Have you been	hospitalized	l for anything else n	ot disc	cussed?		
DATE		HOSPITAL		REASON FOR ADMISS	ION	DURATION OF STAY
	<u> </u>					<u> </u>
						,
AMILY HISTORY:						
	AGE	STATE OF HEALTH		SPECIFIC AILMENTS	A	IF DECEASED, .GE AT DEATH & CAUSE
MOTHER						
FATHER			-			
BROTHER BROTHER				* ************************************		
SISTER						
SISTER						
				·		
lictory of any of the fol	lowing in m	andoarents uncles	onnte	relatives and list relation	achin:	4
•		-			-	
reast Cancer		<del>~</del>				
Piabetes						
terine Cancer						
						100
Other Familial diseases:	<del> </del>					· · · · · · · · · · · · · · · · · · ·
•						
f there is any other pert	inent medic	al information not p	previou	isly mentioned, please d	iscuss:	
	<del></del>					
		<del></del>				····
	·					,
<u> </u>	~					

.